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The Indiana
Family and Social Services Administration

Policy Manual
for the

Indiana Medicaid Home and Community-Based Services Waiver for Persons with Autism

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Table of Contents

5 Provider Qualifications

5.1 Residential Habilitation and Support/Community Habilitation and Participation
5.2 Independence Assistance Services (IAS)
5.3 Community Educational/Therapeutic Activities (CETA)
5.4 Respite Care
5.5 Prevocational Services
5.6 Supported Employment Follow-Along)
5.7 Health Care Coordination
5.8 Family and Caregiver Training
5.9 Physical Therapy
5.10 Occupational Therapy
5.11 Speech/Language Therapy
5.12 Recreational Therapy
5.13 Music Therapy
5.14 Psychological Therapy
5.15 Nutritional Counseling
5.16 Enhanced Dental Services
5.17 Behavior Management/Crisis Intervention
5.18 Applied Behavior Analysis (ABA)
5.19 Environmental Modifications, Specialized Medical Equipment and Supplies, Personal Emergency Response Systems, and Specialized Medical Equipment and Supplies Assessment/Inspection/Training
5.20 Transportation
5.21 Driver Services (Transportation Supports)

10 Appeals and Hearings

11 Related Documents Available at:

http://www.in.gov/fssa/servicedisabl/waivers.html
and
www.in.gov/fssa/servicedisabl/provider/providerapproval.html

- Title 460 Division of Disability, Aging, and Rehabilitative Services Final Rule 460 IAC 6 (http://www.in.gov/legislative/iac/title460.html)
- Person Centered Planning Guidelines (http://www.in.gov/fssa/servicedisabl/bqis/pcpguidelines.html)
- Instructions for Completion of the Individualized Support Plan (http://www.in.gov/fssa/servicedisabl/bqis/ispinstruct.html)
- Incident Reporting (http://www.in.gov/fssa/servicedisabl)
- Complaint Process (http://www.in.gov/fssa/servicedisabl/)
- A Guide for Individuals Working With the Bureau of Developmental Disabilities Services (http://www.in.gov/fssa/servicedisabl/ddars/index.html)

1. Roles and Responsibilities

The Divisions within FSSA and other entities involved in the day-to-day operation, and/or the oversight of the waiver are:

1.1 The Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, under the U.S. Department of Health and Human Services is the Federal agency that administers the Medicare and Medicaid programs which provide health care to the aged and indigent populations. (In Indiana, the Medicaid program serves indigent families, children, pregnant women, senior citizens, persons with disabilities, and persons who are blind.)

To provide home and community based Medicaid services as an alternative to institutional care, a state submits to CMS, a request to "waive" the Social Security Act requirement that comparable services must be offered statewide to all Medicaid recipients. (Section 1915c of the Social Security Act allows this waiver of Medicaid requirements.) CMS reviews all waiver requests/applications, renewals, amendments, and financial reports. Additionally, CMS performs management reviews of all Home and Community-Based Services (HCBS) Waivers to ascertain their effectiveness, safety, and cost-effectiveness. The Autism Waiver will receive a management review by CMS in 2006, prior to its expiration December 31, 2006.

CMS requires states to assure that federal requirements for waiver service programs are met and verifies that the states' assurances in their waiver program are being upheld in their day to day operation.

1.2 The Division of Disability, Aging, and Rehabilitative Services (DDARS)

The Bureaus within DDARS that work directly on the development and operation of the Autism Waiver are: the *Bureau of Developmental Disabilities Services (BDDS)* and the *Bureau of Quality Improvement Services (BQIS),* which includes the DD Ombudsman.

1.2.1 The Bureau of Developmental Disabilities Services (BDDS)

BDDS has statutory authority over state programs and is the placement authority for persons with developmental disabilities and assists with the development of policies and procedures for Indiana Medicaid waivers that serve persons with developmental disabilities.

1.2.2 The Bureau of Quality Improvement Services (BQIS)

BQIS provides technical support to all offices in DDARS to assist with the implementation of quality improvement systems and provides technical support to all offices in DDARS to assist with the implementation of quality improvement processes. The Quality Monitors, co-located in BDDS Regional Offices, work under BQIS.

1.2.3 DD Ombudsman

The DD Ombudsman receives, investigates, and assists in the resolution of complaints and concerns that are made by or on behalf of an individual who is developmentally disabled and receives services under a Medicaid waiver.

1.3 The Office of Medicaid Policy and Planning (OMPP)

The Office of Medicaid Policy and Planning has the ultimate responsibility to oversee HCBS waiver programs. Although DDARS operates the waiver program, OMPP exercises administrative discretion in the administration and supervision of policies, rules, and regulations related to the waiver. OMPP approves any waiver report, application, or amendment prior to submission to CMS. Additionally, OMPP is active in the development of quality assurance functions.

1.3.1 Electronic Data Systems Corporation (EDS)

EDS is the Indiana Medical Assistance Programs contractor. All bills for Medicaid waiver services are submitted and paid through EDS. Additionally, OMPP has contracted EDS to perform audits of Medicaid

waiver service providers to assure that services provided are appropriately reimbursed and properly documented.

1.4 Intake Targeted Case Management

The two possible providers of intake case management services for persons with developmental disabilities are: 1) Bureau of Developmental Disabilities Services District Offices (BDDS); and 2) participating Area Agencies on Aging (AAA).

1.4.1 The Bureau of Developmental Disabilities (BDDS)

Nine local BDDS offices serve as points of entry for all individuals seeking developmental disability services. BDDS has the statutory authority to determine an individual's eligibility for developmental disability services by establishing that the individual has a developmental disability according to the state definition.

1.4.2 Area Agencies on Aging (AAAs)

AAAs act as the point of entry for a number of community-based programs. Several of the 16 local AAAs serve providers of intake case management for persons with developmental disabilities.

1.5 On-Going Targeted Case Management*

There are two (2) entities that may provide on-going case management: 1) Area Agencies on Aging (AAAs); and 2) independent entities.

1.5.1 Area Agencies on Aging (AAAs)

After it has been determined by the BDDS office that a Medicaid recipient has a developmental disability, the individual may choose a case manager employed by a participating AAA to provide on-going case management.

* Case management agencies will be certified by DDARS. Individual case managers will be certified by the agencies that employ or contract them.

1.5.2 Independent Entities

After it has been determined by the BDDS office that a Medicaid recipient has a developmental disability, the individual may choose an independent case manager, or an independent agency that employs qualified case managers, to provide on-going case management.

1.6 Division of Family and Children

The local Division of Family and Children office of the Family and Social Services Administration, has the responsibility to determine an individual's eligibility for Medicaid. Applicants must meet categorical (aged, blind, low income families, disabled, or disabled worker), financial, and non-financial eligibility requirements.

1.7 Service Providers

Service providers are agencies, companies, and individuals that have been certified as waiver service providers and are paid by Medicaid to provide direct services to Medicaid waiver program participants. Service providers may be community developmental disabilities agencies, home health agencies, community mental health centers, occupational therapists, psychologists, nurses, nutritionists, family members, public/private transportation providers, etc.

2. Eligibility

2.1 Medicaid Eligibility for the Aged, Blind, and Disabled

Medicaid is a Federal and State funded health care program that pays for medical services provided to individuals who meet specific eligibility requirements (listed below). The program serves families, children, pregnant women, senior citizens, persons with disabilities, and persons who are blind.

Recipients of services under the Autism Waiver will meet Medicaid eligibility under the "Aged, Blind, Disabled, Low-Income Families, or Employees with Disabilities (referred to as M.E.D. Works)" categories appearing as MA-A; MA-B; MA-D; MA-C; and MA-DW, respectively in Medicaid's Indiana AIM Database. (Local Division of Family and Children (DFC) offices are responsible for the determination and redeterminations of eligibility for Medicaid).

Applications are filed with the local DFC in the county where the applicant lives. *An individual has the right to apply for Medicaid without delay or discrimination and to receive written notice of the eligibility determination.* Medicaid eligibility may be retroactive up to three months prior to the month in which the application was received by the local DFC.*

An individual has the right to appeal any action taken with regard to his/her eligibility for Medicaid. To file an appeal, a written request for a fair hearing must be sent to the local Office of Family and Children or to the Hearings and Appeals Section, Family and Social Services Administration.

To be eligible for Medicaid as an individual who is aged, blind or disabled, the individual must meet categorical, non-financial, and financial eligibility requirements.

* If at the time of application, a waiver applicant is not a Medicaid recipient, case management may not be billed to Medicaid. Medicaid may be billed at a later date, if the applicant is determined to be eligible for Medicaid and the Medicaid effective date is retroactive to at least the date of the waiver application. However, a Targeted Case Manager providing Case Management before the date of approval assumes the risk that the person will be found ineligible and services will not be able to be billed.

2.1.1. Categorical Eligibility

The following five categories receive the full range of Medicaid services. (Financial/non-financial eligibility must also be met.)

- **Aged** - Age 65 and older.
- **Blind** - Generally stated, the definition of blindness in Indiana law is as follows: Central visual acuity of 20/200 or less in the better eye with correction, or a visual field contraction of no more than 20 degrees. Persons receiving Supplemental Security Income (SSI) due to blindness automatically meet this requirement.
- **Disabled** - Generally stated, the definition of disability in Indiana law is as follows: A physical or mental condition that appears reasonably certain to result in death or to last for a continuous period of at least four years without significant improvement, and which substantially impairs the person's ability to work in a useful occupation. Persons who are receiving SSI do *not* automatically meet this requirement.
- **Low-Income Families**-Families with children under the age of 18. This includes families who receive cash assistance under the Temporary Assistance to Needy Families (TANF) program, and those who do not. (TANF provides cash assistance and supportive services to families with children under the age of 18 who are deprived of financial support from a parent by reason of death, absence from the home, unemployment, or physical or mental incapacity.
- **Employees with Disabilities-Referred to as "M.E.D. Works",** covers individuals who are age 16-64 who meet the above definition of Disability, except for the fact that they are employed. (See http://www.in.gov/fssa/healthcare/med/ for additional information on M.E.D. Works.)

2.1.2 Non-Financial Eligibility

If an individual fits into one of the previously listed categories, the following eligibility criteria must also be met:

- Must be a resident of Indiana;
- Must be a U.S. citizen or a non-citizen in an eligible immigration status. Except for refugees, parolees, and persons whose deportation is withheld, lawful immigrants

who enter the country after August 22, 1996, are not eligible for full Medicaid coverage for 5 years. During that time, however, they may receive coverage for emergency medical care if they meet all other eligibility requirements. Additionally, immigrants who have no proof of legal residence in the U.S. are entitled to emergency services if other eligibility requirements are met;

- Must furnish his/her Social Security number;
- Must assign to the State all rights to medical support and payments for medical care that could be available from any third party such as insurance or a non-custodial parent. Individuals must cooperate in providing information about responsible third parties and obtaining third party payments and medical support, unless the individual establishes good cause for not complying.

2.1.3. Financial Eligibility

Financial eligibility is based on the income and resources/assets of the individual and his or her spouse.

2.1.3.1 Income

Aged, Blind, Disabled
Income limits are the same as the maximum benefit payable under the SSI program, and increase in January of each year based on the Social Security cost of living adjustment (COLA). "Countable" income from employment is calculated by subtracting $65 from the gross income and dividing by 2. If the applicant is a child, the income of the child's parents is counted unless the child is receiving services under a Home and Community-Based Services Waiver.

Low-Income Families
Income limits are the same as those used in the TANF program, approximately 24% of the federal poverty level.

M.E.D. Works (Employees with Disabilities)
The individual's countable income after certain deductions cannot exceed 350% of the federal poverty level (as of 1/1/03, $2586/month for a single person).

2.1.3.2 Resources

Aged, Blind, and Disabled
For these categories the resource limits are:

- $1500 Individual; one parent of a child applicant
- $2250 Married couple; two parents of a child applicant

(For the **Aged, Blind, and Disabled** categories, there are many kinds of resources that are not counted: the home, irrevocable funeral trusts, income-producing real estate, real estate that is used to produce food for home consumption, real estate that is being offered for sale or rent at fair market value, resources that were protected by purchasing and using an Indiana partnership long term care insurance policy, and, in most cases, one car. Resources that count include: checking and savings accounts, certificates of deposits, stocks, bonds, and the cash value of most life insurance policies).

M.E.D. Works (Employees with Disabilities)
For this category the resource limits are:
$2000 Individual
$3000 Married Couple

For the above categories, parental resources are exempt.

Low-Income Families
For this category, the resource limit is $1000 for the family.

2.1.3.3 Spend-Down

An individual whose income exceeds the established income levels can still be eligible for Medicaid under the "spend-down provision". An individual's spend-down is the amount of income that is over the limit for his or her family size. If the individual's medical expenses are more than his/her "excess income" (spend-down amount) he/she can be eligible. Medicaid pays for medical expenses over and above

the spend-down. The individual must show proof (bills, receipts, statement, etc.) of incurred medical expenses (paid or unpaid). When the incurred medical expenses equal the spend-down amount, Medicaid coverage will be available the remainder of that month. A spouse's medical bills count toward meeting spend-down, and if the recipient is a child, his or her parents' medical bills count.

2.1.3.4 Senate Bill 30

Senate Bill 30 (1991) is a provision which allows parental income and resources to be disregarded when determining Medicaid eligibility for children under age 18 who are in a Medicaid certified facility or being considered for a Medicaid HCBS waiver program in lieu of institutionalization. The exclusion of parental income and resources applies only as long as the child is a Medicaid waiver program participant. The inclusion of parental income in the determination of a child's eligibility for Medicaid resumes beginning the month following the month in which Medicaid waiver services are discontinued if the child continues to live with his/her parent(s).

2.2 Autism Waiver Eligibility

Indiana has assured the Centers for Medicare and Medicaid Services that the following requirements for individuals who participate in a home and community-based waiver are met:

2.2.1 Level of Care/Risk of Institutionalization

One of the requirements of the Social Security Act is that only individuals who would be at risk of institutionalization without the provision of home and community-based services, receive home and community-based services. An individual with a developmental disability must meet the criteria (the level of care) for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and have a diagnosis of Autism to be eligible for the Autism Waiver program participation.

2.2.2 Health and Safety

It must be determined that any program participant can be served safely in the community. This is accomplished in general, through Indiana's quality assurance program design and application, as well as through plan of care development and provider qualifications and training. However, a statement from a physician (a Form 450B) must be obtained for each individual waiver program applicant, that the individual can safely receive community supported in-home care.

2.2.3 Cost Neutrality

Indiana must demonstrate that average per capita expenditures for the Autism Waiver program participants are equal to or less than the average per capita expenditures of institutionalization for the same population.

2.2.4 Choice

When an individual is determined to be likely to require an ICF/MR level of care and has a diagnosis of Autism, he/she or the legal representative, must be informed of any feasible alternatives under the waiver and given the choice of either institutional or home and community-based services.

2.3 Medicaid State Plan Services/Prior Authorization

Individuals who receive services under a Medicaid HCBS waiver are also eligible to receive traditional services under the "regular" Medicaid program (State Plan services) such as physician services, medications, laboratory services, etc. Some services provided under the Autism Waiver are also available under the State Plan. These services are: physical therapy, speech/language therapy, occupational therapy, specialized medical equipment and supplies, and transportation.

States have options in the amount, duration, and scope of the services that are provided under the State Plan. For example, physical therapy available under the State Plan must be authorized by Medicaid prior to its provision. Further, the amount, duration, and scope of the therapy will be limited to address a specific acute condition. State Plan services are primarily

restorative or remedial in nature and are not aimed at ameliorating a particular disabling condition. Therefore, it may be reasonable for an Autism Waiver participant to receive physical therapy beyond what is available under the State Plan. If physical therapy is identified as a need on the individual's plan of care, and it has been documented that State Plan physical therapy is not appropriate or has been exhausted, the individual may receive physical therapy under the waiver.

2.4 Hoosier Healthwise

Parents and children receiving Temporary Assistance for Needy Families (TANF) as well as non-TANF pregnant women and children with incomes at or just about the poverty level may choose to participate in Hoosier Healthwise.

The Hoosier Healthwise Program consists of:

- Primary Care Case Management;
- Risk-Based Managed Care; and
- Managed Care for Persons with Disabilities.

Medicaid recipients are not allowed to enroll in both the HCBS Waiver Program and Hoosier Healthwise. They must choose one program or the other.

2.5 Hospice Services

Individuals who receive Medicaid HCBS and elect to use the Indiana Health Care Program Hospice benefit do not have to disenroll from their waiver program; however, they must come under the direct care of the hospice provider for those services held in common by both programs. In short, the waiver member who elects the hospice benefit may still receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. The hospice provider, waiver case manager, and the local Area Agency on Aging must collaborate and communicate regularly to ensure the best possible overall care to the waiver/hospice member.

3. Ongoing Eligibility*

3.1 Level of Care Re-Assessment

Autism Waiver program participants must be re-determined each year to meet ICF/MR level of care and have the diagnosis of Autism. Annual level of care re-determinations for the Autism Waiver are completed by OMPP for children who have not reached their 6th birthday. Annual level of care redeterminations for the Autism Waiver are completed by the case manager (who must be a Qualified Mental Retardation Professional {QMRP}), or a designated QMRP, for children age 6 years and older and for all adults. (See Section 8 for additional information.)

3.2 Plan of Care Update

All Autism Waiver program participants must have a new Plan of Care, Service Planner and Cost Comparison Budget each year that covers the same months of the year as the initial ones. The targeted case manager is responsible for facilitating an update to the Person Centered Plan and Individualized Support Plan with the individual, guardian, and anyone else the individual requests. Updates to the Plan of Care, Service Planner and Cost Comparison Budget may be made within the annual period to reflect changes in the individual's needs or service providers. (See Section 8 for additional information.)

3.3 Medicaid Eligibility Re-Determination

It is the local Division of Family and Children office's responsibility to determine each year the individual's continuing eligibility to receive Medicaid.

* See Section 8 for details.

4. Service Definitions *

4.1 Residential Habilitation and Support

Residential Habilitation and Support services provide up to a full day (24-hour basis) of services and/or supports which are designed to ensure the health, safety and welfare of the individual, and assist in the acquisition, improvement, and retention of skills necessary to support individuals to live successfully in their homes. These services are individually planned and coordinated through the person's Plan of Care, while the frequency, duration and scope of these services are identified in the Individualized Support Plan. These services may include a combination of lifelong (or extended) supervision, training, and/or support which are essential to daily living.

Activities allowed: Supervision, monitoring, training, education, demonstration, or support (support being any task performed for the individual where learning is secondary or incidental to the task itself, or an adaptation is provided) to assist with behavior plan implementation, the acquisition, improvement and retention of life skills, assistance with meals, shopping, medical appointments, running errands, and household care/chores. At any one time, any of the services may be delivered, depending on the needs of the individual.

Activities not allowed: Payment will not be made for services furnished to a minor by the parent(s) or step-parent(s) or to an individual by that person's spouse. Structural modifications to the home are not allowed.

4.2 Independence Assistance Services (IAS)

Independence Assistance Services provides supports that the individual needs to maintain independence to live successfully in his/her home, as outlined in the Individualized Support Plan and coordinated through the individual's Plan of Care. There are two tiers (per month) available based on the required service needs of the individual. Persons requiring fewer than 20 hours of services per month (based on the recommendation of the individual's support team) are in Tier 1. Persons requiring more than 20 hours of service per month are in Tier 2. In order to qualify for Independence

* All services are provided as specified in an individual's support plan.

Assistance Services, individuals must require fewer than 30 hours of residential assistance services per month.

Activities allowed: These services may include, but are not limited to, assistance in paying bills, shopping for groceries, personal care and services, homemaker/chore services, attendant care and companion services, medication oversight, and other appropriate supports. Independence Assistance Services may be provided to individuals living with their family members, except to minors living with their parents/guardians. Other services individuals may receive in addition to Independence Assistance Services include "day services", therapies, Health Care Coordination, Transportation, Rent and Food for an Unrelated Live-In Caregiver.

Activities not allowed: Individuals may not receive additional Residential Habilitation and Support. Individuals who require more hours of Residential Habilitation and Support than are provided by Independence Assistance Services should have their services funded through the "traditional" service planner. If the individual is in a crisis, hours of Residential Habilitation and Support may be added to the plan for up to 30 days and be provided in tandem with IAS. However, if additional supervision is expected to last more than 30 days, the plan should be amended to remove the Residential Habilitation and Support.

4.3 Community Habilitation and Participation

Community Habilitation and Participation are services outside of the home that support learning and assistance in the areas of: self-care, sensory/motor development, socialization, daily living skills, communication, community living, or social skills. This service includes supportive services in child day care centers which address needs attributable to the disability (excluding the cost of child care).

The support needed to participate in educational experiences and training through generic entities such as trade schools, vocational technical schools, adult education, unpaid work experience in community settings, volunteering, and spectator sports, are included when not funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

Community Habilitation and Participation services provide individuals access to and participation in typical activities and

functions of community life that are desired and chosen by the general population. Community Habilitation and Participation provides support or a combination of training and supports that afford a wide variety of opportunities to facilitate and build relationships and natural supports in the community. Such activities may include opportunities to experience and participate in community exploration, companionship with friends and peers, leisure activities, hobbies, maintaining family contacts, community events, and those activities and services where persons without disabilities are involved. Personal care needed to assure participation in educational, social, or community activities is included.

Community Habilitation and Participation services also include training and education in self-determination designed to help individuals achieve one or more of the following outcomes: 1) develop their self-advocacy skills; 2) exercise their civil rights; 3) acquire skills that enable them to exercise control and responsibility over the services and supports they receive; or 4) acquire skills that enable them to become more independent, integrated, or productive in their communities.

Community Habilitation and Participation shall be furnished outside of the person's own home or residential setting (but including the homes of other friends and family for social activities) or the community at large. Community Habilitation and Participation services do not include activities that would normally be a component of a person's residential life or services. Counseling and assistance to obtain housing is considered a Community Participation service. Housing counseling consists of identifying options for either rental or purchase, including identifying financial resources, assessing adaptations and accessibility needs, locating housing and planning for on-going management and maintenance of the home. Moving expenses are <u>not</u> included under Community Habilitation and Participation.

4.3.1 Community Educational/Therapeutic Activities (CETA)

CETA services include the costs of participating in community activities such as tuition for vocational classes, fees for therapeutic horseback riding, camps, public events, etc. This would include separate charges beyond the cost of the Community Habilitation and Participation services. There is an allowance of $2,000 per year for these individualized

activities which must be included in the approved Plan of Care/Cost Comparison Budget and Individualized Support Plan. See Section 6 regarding reimbursement for these services.

Activities Allowed: Activities to assist with the acquisition and retention of skills, leisure activities, community events, educational activities, hobbies, unpaid work experience, public events, and maintaining contact with friends and family. The individualized Support Plan must include a thorough explanation of the particular CETA activity in order to document the educational/therapeutic nature of the activity.

Activities not allowed: Services that are available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act may not be provided. Recreational/leisure activities shall be provided only for these types of activities that are therapeutic in nature (rather than solely diversional) or that assist in developing and /or maintaining natural supports. Payment will not be made for services furnished to a minor by the parent(s) or step-parent(s) or to an individual by that person's spouse. Transportation costs are not allowed. Costs incurred for trips beyond the states bordering Indiana are not allowed. Moving expenses are also not allowed.

Providers of Residential Habilitation and Support or of Community Habilitation and Participation are all automatically approved to provide CETA. Individuals do not pay for activities or services that are part of CETA. The provider pays for the service/activity and then bills the waiver to be reimbursed for the cost. If an individual does not have a Residential Habilitation or Community Habilitation provider in his or her Plan of Care/Cost Comparison Budget, it will be necessary to find one who is willing to be the fiscal intermediary for this service.

4.4 Respite Care

Respite Care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite Care may be provided in the individual's home or place of residence, a foster home, outside of the home

environment in a non-private residential setting for an individual or group, or in the home of a care provider.

Activities not allowed: Respite care must not be utilized as an alternative to day/child care while the caregiver goes to work. The cost of room and board is excluded.

4.5 Adult Day Services

Adult Day Services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, recreational and therapeutic activities, supervision, support services, and personal care. Meals and/or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. Each meal must meet 1/3 of the daily Recommended Dietary Allowance. These services must be provided in a congregate, protective setting.

Participants attend Adult Day Services on a planned basis. A minimum of 3 hours to a maximum of 12 hours shall be allowable. There are three levels of Adult Day Services: Basic, Enhanced, and Intensive:

- Basic Adult Day Service (Level 1) includes:
  a) Monitor and/or supervise all activities of daily living (ADLs) defined as dressing, bathing, grooming, eating, walking, and toileting) with hands-on assistance provided as needed;
  b) Comprehensive, therapeutic activities;
  c) Health assessment and intermittent monitoring of health status;
  d) Monitor medication or medication administration; and
  e) Appropriate structure and supervision for those with mild cognitive impairment.

- Enhanced Adult Day Service (Level 2) includes:
  (Level 1 services requirements must be met.)
  a) Hands-on assistance with 2 or more ADLs or hands-on assistance with bathing or other personal care.
  b) Health assessment with regular monitoring or intervention with health status;
  c) Dispense or supervise the dispensing of medications to participants;

d) Psychosocial needs assessed and addressed, including counseling as needed for participants and caregivers; and
e) Therapeutic structure, supervision and intervention for those with mild to moderate cognitive impairments.

- Intensive Adult Day Service (Level 3) includes:
  (Level 1 and Level 2 service requirements must be met.)
  a) Hands on assistance or supervision with all ADLs and personal care;
  b) One or more direct health intervention(s) required;
  c) Rehabilitation and restorative services including physical therapy, speech therapy, occupational therapy coordinated or available;
  d) Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care; and
  e) Therapeutic interventions for those with moderate to severe cognitive impairments.

4.6 Prevocational Services

Prevocational services are aimed at preparing an individual for paid or unpaid employment, by teaching such concepts as compliance, attendance, task completion, problem solving and safety. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, and shall be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Prevocational services are compensated at less than 50 percent of the Federal Minimum Wage. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional workshop within one year (excluding supported employment programs). For Prevocational Services to be utilized appropriately for people, it is necessary to make a calculation on a per-task basis. Compensation of 50% or more of minimum wage is considered Sheltered Work and would be billed to Title 20 and not to the waiver.

Activities not allowed: Services available under a program funded under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act are not allowable under the waiver.

4.7 Supported Employment Follow-Along

Supported Employment services consist of services which support paid employment for persons for whom competitive employment at or above the Federal Minimum Wage is unlikely without the provision of Supported Employment, and who, because of their disabilities, need intensive on-going support to perform in a competitive work setting. Supported Employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

Activities allowed: Screening/evaluation, job exploration, job development, job search activities, job site visits, employment advocacy, job coaching/training, documentation, supervision, follow-along, travel, and mobility training to the job site are allowable activities. Activities may include time spent with advocates, family members, guardians, etc. that facilitates the acquisition/maintenance of employment.

Activities not allowed: Transporting the consumer to and from the job site is not allowed. Advocacy activities not related directly to work that would be provided by Targeted Case Management are not allowable. Training and education that is provided off the job site is not allowable (except for mobility training related to the job). Services are not allowable that are otherwise available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. It must be demonstrated that Vocational Rehabilitation eligibility has been pursued. Incentive payments made to an employer to subsidize the employer's participation in a supported employment program, payments that are passed through to users of Supported Employment programs, and payments for vocational training that is not directly related to an individual's supported employment program are not allowable.

4.8 Health Care Coordination

Health Care Coordination includes medical coordination provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to manage the health care of the individual including physician consults, medication ordering, development and oversight of a heath care support plan. Skilled nursing services are provided within the scope of the Indiana State Nurse Practice Act. The purpose of

Health Care Coordination is stabilization, prevention of decompensation, management of chronic conditions, and/or improved health status.

Because of the different benefits provided under Skilled Nursing and Health Care Coordination, Medicaid Prior Authorization for skilled nursing services is **not necessary** prior to the provision of Health Care Coordination. Health Care Coordination consists of the following levels:

1 Unit - Health care needs require at least weekly consultation/review by RN/LPN with face to face visits once a month.

2 Units - Health care needs require at least weekly consultation/review by RN/LPN with face to face visits at least twice a month.

3 Units - Health care needs require at least twice weekly consultation/review by RN/LPN with face to face visits once a week.

4 Units - Health care needs require at least twice weekly consultation/review by RN/LPN with face to face visits at least twice a week.

The appropriate level should be determined by a healthcare professional (LPN, RN, Doctor) as part of the individual's support team.

Activities not allowed: Skilled nursing services or other medical services, that are available under the Medicaid State plan, services that are not specified in the individualized support plan, case management services provided under a 1915 (b), 1915 (c) or 1915 (g) case management waiver, or residential, vocational, and/or educational services otherwise provided as part of Autism Waiver services are not allowable.

4.9 Family and Caregiver Training

Family and Caregiver Training services include training and education to instruct a parent, other family member, or (unpaid) primary caregiver about the treatment regimens and use of equipment specified in the Individualized Support Plan, and to assist in improving the caregiver's ability to give care. Family and

Caregiver Training is provided by individuals, agencies, and/or educational facilities that have demonstrated expertise in the area of training needed by the caregiver(s).

Activities Allowed: Allowable activities include instruction in treatment regimens, use of equipment, stress management, parenting, family dynamics, community integration, medically fragile individuals, behavioral intervention strategies, mental health, conferences, seminars (in or out-of-state training).

Activities Not Allowed: Training/instruction not pertinent to the caregiver's ability to give care to the individual or training provided to caregivers who receive reimbursement for training costs within their Medicaid reimbursement rate are not allowable. Airfare, meals and hotel costs are not allowable.

4.10 Physical Therapy

Physical therapy is the provision of treatment and training programs designed to preserve and improve abilities for independent functioning such as gross and fine motor skills, range of motion, strength, muscle tone, activities of daily living, mobility, and prevent progressive disabilities through such means as the use of purposeful activities, orthotic and prosthetic devices, assistive and adaptive equipment, positioning, behavior adaptation, and sensory stimulation.

Physical therapy services consist of the full range of activities provided by a licensed physical therapist. These services include:

- Screening;
- Assessment;
- Development of therapeutic treatment plans;
- Direct therapeutic interventions;
- Training and assistance with adaptive aids;
- Consultation with other service providers and family members; and
- Participating on the interdisciplinary team, when appropriate.

The licensed and registered physical therapist or qualified paraprofessional may provide services directly or may demonstrate techniques to other service personnel or family members.

Indiana's State Plan provides for the coverage of physical therapy services. Such services, however, are limited to services which are principally restorative or remedial in nature and do not include services which have habilitative or assistive objectives aimed at ameliorating a particular handicapping condition.

Activities Not Allowed: Physical therapy services will not be furnished to a program participant under the waiver program unless it is demonstrated that such services (habilitative in nature) are not available under the State Plan.

4.11 Occupational Therapy

Occupational therapy is the provision of evaluation and training services in the areas of gross and fine-motor function, self-care and sensory and perceptual motor function. Remedial techniques include the design, fabrication, and adaptation of materials and equipment to individual needs. The registered therapist or qualified paraprofessional may provide services directly or may demonstrate techniques to other service personnel or family members.

Activities Not Allowed: Occupational therapy will not be furnished to a program participant under the waiver program unless it is demonstrated that such services (habilitative in nature) are not allowable under the State Plan.

4.12 Speech/Language Therapy

Speech/Language Therapy is the provision of evaluation and training services to improve the ability to use verbal or non-verbal communication. This may include language stimulation and correction of defects in voice, articulation, rate, and rhythm. To be eligible for this service, the individual must have been examined by a certified audiologist and/or a certified speech therapist who has recommended a formal speech/audiological program.

Services consist of individual and group therapy for the treatment of speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries and hearing handicaps requiring specialized auditory training, lip reading, signing, or use of hearing aids. The licensed speech pathologist or qualified paraprofessional may provide services directly or may demonstrate techniques to other service personnel or family members.

Activities Not Allowed: Speech/Language Therapy will not be provided to a program participant under the waiver program unless it is demonstrated that such services (habilitative in nature) are not available under the State Plan.

4.13 Recreational Therapy

Recreational Therapy is the planning, organizing, and directing of a medically approved recreation program by a qualified Recreational Therapist, based on the individual's capabilities needs, and interests, such as dramatics, games, social activities, art stress reduction, individual and group sports, etc. and regulating the program in accordance with the individual's capabilities, needs, and interests. The purpose of Recreational Therapy is to restore, remediate, or rehabilitate in order to improve the functioning and independence, as well as to stabilize, reduce, or eliminate the effects of a disability. Recreational Therapy includes consultation with and preparation of reports for the individual's physician, other members of the support team, and service providers, as well as the supervision and provision of in-service training of other caregivers.

Allowable Activities: The Recreational Therapist may provide services directly or may demonstrate techniques to other service personnel or family members.

4.14 Music Therapy

Music Therapy is the systematic application of music in the treatment of the physiological and psychosocial aspects of a disability. It focuses on the acquisition of nonmusical skills and behaviors, as determined by a qualified Music Therapist.

Goals of Music Therapy:

- To improve self-image and body awareness;
- To increase communication skills;
- To increase the ability to use energy purposefully;
- To reduce maladaptive (stereotypic, compulsive, self-abusive, assaultive, disruptive, perserverative, impulsive) behaviors;
- To increase interaction with peers and others;
- To increase independence and self-direction;
- To stimulate creativity and imagination;
- To enhance emotional expression and adjustment;

- To increase attending behavior;
- To improve fine and gross motor skills; and
- To improve auditory perception.

The Music Therapist may provide services directly or may demonstrate techniques to other service personnel or family members. Special equipment needed for the provision of recreational therapy should be purchased under "Specialized Medical Equipment and Supplies".

4.15 Psychological Therapy

Psychological Therapy is interaction between a qualified Psychologist and the individual that leads to changes from a less adaptive state to a more adaptive state in the individual's thoughts, feelings, and behavior. Psychological Therapy includes activities such as: biofeedback; client-centered therapy; cognitive-behavioral therapy; psychiatric services; crisis counseling; family therapy; substance abuse counseling and intervention; and group therapy.

4.16 Nutritional Counseling

Nutritional Counseling consists of an evaluation and medically approved nutritional counseling by a qualified Dietician to improve the individual's nutritional lifestyle and wellness. Dieticians work directly with an individual to analyze needs, develop and monitor nutritional plans and educate, advise, support and monitor the individual, the individual's service personnel, and/or family.

4.17 Enhanced Dental Services

Enhanced Dental Services are dental procedures provided by a licensed dentist to only those individuals with dental problems which are sufficient to lead to more generalized disease due to infection or improper nutrition which would require institutionalization. **All State plan dental coverage must be sought and exhausted prior to utilizing this service.**

4.18 Behavior Management/Crisis Intervention

Behavior Management includes training, supervision, or assistance in appropriate expression of emotions and desires, compliance,

assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors. Crisis intervention is the behavioral or environmental interventions necessary to stabilize and preserve the client's community living arrangement thereby avoiding institutionalization. Crisis intervention includes the provision of services to the individual within his/her own home or residential setting as well as in residential settings other than the usual place of residence.

To be approved to provide behavioral support services as a licensed Level 1 clinician, an applicant must be a licensed psychologist under IC 25-33-1 and have an endorsement as a health service provider in psychology (HSPP) pursuant to IC 25-33-1.5 (c). Level 1 Behavior Management consists of attesting that the correct diagnosis is in place, with the appropriate functional analysis with valid behavioral data. Behavior plans may be developed, monitored, and amended by a Level 2 clinician, but a Level 2 clinician must have the supervision of a Level 1 clinician regarding the diagnosis, behavior plan, etc. Supervision of a Level 2 clinician is defined as assistance by the Level 1 clinician with the direction of the behavior plan, review of the behavior plan (including review signature), and review of the application of the particular procedures and their outcomes. The Level 1 clinician will need to sign the behavior plan at least annually, or as often as the Level 1 clinician feels is necessary. This serves as an on-going check that the diagnosis is correct and that the appropriate intervention and treatment is in place from a psychological standpoint. A provider certified to provide Level 1 may also provide Level 2, but a Level 2 clinician must have the participation of a Level 1 provider regarding the diagnosis, behavior plan, etc.

4.19 Applied Behavioral Analysis

Applied Behavioral Analysis (ABA) therapy is highly intensive, individualized instruction and behavioral intervention, a key component of which is "discrete trial therapy" which seeks to use empirically validated behavior change procedures for assisting individuals in developing skills with social value. The primary goals of ABA therapy are to lessen behavioral excesses such as tantrums and acting out behaviors, and to improve communication deficits.

Discrete trial therapy consists of:

- Antecedent: a directive or request for the individual to perform an action;

- Behavior: a response from the individual, including anything from successful performance, non-compliance, or no response;
- Consequence: a reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise, or a negative (not aversive) reaction; and
- A pause to separate trials from each other (intertrial interval).

Key elements of ABA therapy are:

- Highly intensive: typically 30-40 hours a week (with a minimum of 20 hours per week) for a two to three year period. For four to six hours a day to five to seven days a week without breaks for the full year;
- Targeted skills are broken down into small attainable tasks;
- Skills that are prerequisites to language are heavily emphasized, such as attention, cooperation, and imitation;
- Treatment approach is tailored to address the specific needs of the individual, including additional medical needs such as occupational and/or physical therapy, for example;
- Specific program that must include:
  (a) attending skills (to therapist, adults, and peers);
  (b) imitation skills (motor and verbal);
  (c) receptive and expressive language skills development;
  (d) appropriate toy play; and
  (e) appropriate social interaction;
- Treatment must be provided for the recommended <u>two to three year time period</u> <u>between the age of two through seven years;</u>
- One-on-one structured therapy;
- Structure and high consistency in all areas of programming;
- Family training so that skills can be generalized and communication promoted;
- Emphasis on acquiring new behaviors; and
- Success is closely monitored with detailed data collection.

4.20 Environmental Modifications

Environmental modifications are physical adaptations to the home required by the individual to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual, would require institutionalization. Such adaptation may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to

accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

All home modifications must be provided in accordance with applicable State or local building codes. Any modification or item costing more than $500.00 requires an assessment by a qualified professional such as a housing contractor, architect, physician, nurse, occupational therapist, physical therapist, speech and language therapist, or rehabilitation engineer. The cost of the evaluation to determine the need for modifications, as well as the design of those modifications, is included in the cost of this service. There is a $15,000 lifetime cap* on this service. Service/repair up to $500 per year, outside of this cap, is permitted for maintenance and repair of items and modifications.

Modifications not allowed: Excluded are adaptations and modifications to the home that add to the total square footage of the home and are not of direct benefit to the welfare of the individual, or which are of general utility and are not of direct medical or remedial benefit to the individual such as carpeting, roof repair, central air conditioning, etc.

4.21 Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies include devices, controls, or appliances which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Communication devices, items necessary for life support, vehicle modifications, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Specialized Medical Equipment and Supplies includes special equipment needed for music therapy. All items must meet applicable standards of manufacture, design, and installation. (The materials and installation for low-tech adaptations that do not necessarily have manufacturing standards are allowable.) Any individual item costing over $500 requires an evaluation by a qualified professional such as a physician, nurse, occupational therapist, physical therapist, speech and language therapist or rehabilitation engineer.

* The lifetime of the individual, not the lifetime of the waiver.

Items not allowed: Excluded are Medical equipment and supplies furnished under the State Plan and those items which are not of direct medical or remedial benefit to the individual.

4.22 Personal Emergency Response System

A Personal Emergency Response System (PERS) provides immediate assistance in case of a physical, emotional, or environmental emergency through a community-based electronic communications device. This service provides a direct link to health professionals to secure immediate assistance by the activation of an electronic unit in the individual's home. The unit is connected to the telephone line and is programmed to send an electronic message to a community-based 24 hour emergency response center once a "help" button is pushed by the persons in need of help or if the PERS home unit is otherwise activated. There is also a personal "help" button which can either be carried or worn by the subscriber.

4.23 Transportation

Transportation services are those which provide access to community resources. Transportation services consist of material benefits such as tickets/passes, as well as the actual provision of the transportation service. This includes provision for payment to neighbors, co-workers, and other community members using private automobiles to transport individuals for purposes of accessing community resources. As with other services, transportation must be identified in the individual plan as a distinct service.

Level 1 Transportation - the individual does not require mechanical assistance to transfer in and out of the vehicle.

Level 2 Transportation - the individual requires mechanical assistance to transfer into and out of the vehicle (and vehicle must be modified to accommodate the individual);

All individuals who reside in settings with 24-hour paid staff supports are to have the monthly rate established by DDARS for Level 1 or Level 2 Transportation included in their waiver Plan of Care/Cost Comparison Budget (POC/CCB).

Individuals who reside in settings without 24-hour paid staff supports may have the **per mile** rate established by DDARS for Level 1 or

Level 2 Transportation included in their waiver POC/CCB as needed by the individual to gain access to the services and activities specified in their individual plans.

Certified providers of habilitation services are automatically certified as providers of Transportation Levels 1 and 2 for the Autism Waiver. If an individual receives habilitation from more than one provider, the Individual's support team will need to determine which agency to designate the transportation provider.

Services not allowed: Transportation services to medical appointments that are covered under the State Plan are not allowable as waiver services.

4.24 Driver Services (Transportation Supports)

The provider of the Transportation service may also be reimbursed for the time that staff employed by the agency transport the individual to and from services included in the individual's support plan, if not compensated by another service (Community Habilitation and Participation, Residential Habilitation and Support, etc). To encourage providers to transport individuals to meet their unique needs, different rates for Driver services have been established contingent upon the number of individuals who ride for any part of a trip. The rates distinguish services provided to:

- 1 individual
- 2-4 individuals
- 5-8 individuals
- 9 or more individuals

If an individual who receives Residential Habilitation and Support services is driven to another setting where he/she will continue receiving Residential Habilitation and Support, the provider of the transportation service may continue to bill Residential Habilitation and Support during the time in transport. If an individual is being transported from Residential Habilitation and Support services to a Community Habilitation and Participation activity, the transportation provider may bill Community Habilitation and Participation from the time the individual leaves the Residential Habilitation and Support activity to the time the individual returns to Residential Habilitation and Support. If there is a distinct break in habilitation services, the transportation provider should bill Driver Time based on the number of individuals in the vehicle.

When Driver Time is added to the Plan of Care/Cost Comparison Budget, it should be added as DR1 and billed according to the actual number of individuals in the vehicle for each trip. Each individual must be billed for the entire trip at the maximum number using the service for any part of the trip.

4.25 Rent and Food for Unrelated Live-In Caregiver

The State will reimburse the waiver recipient for the additional costs he/she may incur for the room and board of an unrelated, live-in caregiver (who resides in the waiver recipient's home).

- Room is defined as hotel or shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services.
- Board is defined as 3 meals a day or other full nutritional regimen.
- Unrelated means unrelated by blood or marriage to any degree.
- Caregiver is defined as an individual providing a covered service as defined in the waiver to meet the physical, social, or emotional needs.

Reimbursement is not allowable in situations in which the recipient lives in the home of the caregiver or a residence owned or leased by the provider of Medicaid services, or if the individual is a paid caregiver.

Under Medicaid and SSI rules, for payment to not be considered income to the recipient, payment for the portion of the costs of rent and food attributable to an unrelated, live-in caregiver must be made directly to the Medicaid recipient.

This provision does not provide any exceptions to other existing Medicaid requirements resulting in a change in the way an individual's income may be counted in determining Medicaid eligibility or to allow payment to a recipient rather than a provider of service.

This service pays for the portion of rent/food attributable to the un-related live-in caregiver and cannot exceed $545/month.

4.26 Adult Foster Care

Adult Foster Care supports include, but are not limited to, personal care and services, homemaker/chore services, attendant care and companion services, medication oversight and other appropriate supports as described in the Individualized Support Plan. Respite for the Foster Parent will also be included in the rate. Each Adult Foster Care home will be limited to 4 individuals. Other services such as Community Habilitation and Participation and Transportation may also be added to the individual's waiver Plan of Care/Cost Comparison Budget. Residential Habilitation and Support may be added to the plan, as appropriate, to cover for the time when the Foster Parent is working. However, demonstration will need to be made as to why Residential Habilitation and Support is required instead of "day programming" in the community.

There are three levels (tiers) of rates. It is up to the individual's support team to determine what level of supports is required for the individual. It should be based on the number of hours of staffing that would be required if the individual were in a traditional waiver setting. To demonstrate the cost-effectiveness of the service, a Service Planner will be required of the service an individual would be likely to utilize if Adult Foster Care were not available.

Foster Parents are expected to provide the level of support typically provided by a traditional provider agency. Other services, such as "day services" should be added to the Plan of Care as appropriate. The monthly amount also includes an amount (10% of each tier) for Respite. The provider will address in Adult Foster Care policies how this Respite will be handled.

Households in existence under the Alternative Families for Adults (AFA) program prior to January 1, 2003, may continue to provide services for the number of individuals for which certification was previously granted. The new rate structure and other rules apply.

4.27 Person Centered Planning Facilitation

Person Centered Planning (PCP) Facilitation is the process whereby individuals, with the support of their families, are guided through the planning and allocation of resources to meet their own life vision and goals. The PCP Facilitation process is reimbursed only when the individual chooses someone other than the Targeted Case Manager as the PCP facilitator.

A PCP facilitator directs the process by involving the individual, assuring understanding of the discussion, observing themes, and guarding against immediate or old solutions. The PCP Process facilitator prepares for the PCP meeting, maintains focus, and redirects concerns unrelated to the development of an individualized Support Plan.

This planning process:

- Should be based on the focus person's preferences, dreams, and needs;
- Should support long-term hopes and dreams;
- Recognizes how the focus person makes decisions;
- Reveals what the focus person loves and dislikes;
- Is supported by a short-term support plan that is based on reasonable costs given the focus person's support needs;
- Includes the focus person's responsibilities;
- Includes a range of supports including funded, community and natural supports; and
- Should be conducted whenever needed or at least annually.

4.28 Community Transition

Community Transition Services include reasonable, **one-time** set-up expenses for individuals who make the transition from an institution to their own home in the community and will not be reimbursable on any subsequent move. "Own home" is defined as any dwelling, including a house, apartment, condominium, trailer, or other lodging that is owned, leased, or rented by the individual and/or the individual's guardian or family, or a home that is owned and/or operated by the agency providing supports.

Items purchased through Community Transition Services are the property of the individual receiving the service and the individual takes the property with him/her in the event of a move to another residence, even if the residence from which he/she is moving is owned by the DD provider agency.

Services may include all or some of the following:

- Security deposits that are required to obtain a lease on an apartment or home;

- Essential furnishings and moving expenses required to occupy and use a community domicile including a bed, table/chairs, window coverings, eating utensils, food preparation items, bed/bath linens.
- Set-up fees or deposits for utility or service access including telephone, electricity, heating, and water; and
- Health and safety assurances including pest eradication, allergen control or one-time cleaning prior to occupancy.

There is up to $1,000 allowance for this service.

Community Transition Services will **not** include apartment/housing monthly rental expenses, food, appliances, diversional/recreational items such as hobby supplies, television, cable TV access, or VCRs.

5. Provider Qualifications

The Family and Social Services Administration (FSSA) has assured the Centers for Medicare and Medicaid Services that the standards of any State licensure or certification requirements will be met for services or for individuals furnishing services provided under the waiver.

Each individual found eligible for the waiver will be given free choice of qualified providers of each service included in his or her written Plan of Care/Cost Comparison Budget.

5.1 Residential Habilitation and Support/Community Habilitation and Participation

The following provider types may become certified as Residential Habilitation/Support and Community Habilitation/Participation providers under the Autism Waiver:

- Community developmental disabilities agencies, programs, or individuals approved under IC 12-11-1.1;
- Licensed home health agencies per IC16-27-1.

Staff of agencies and individual practitioners must meet all of the following requirements:

- Be at least 18 years of age;
- Demonstrate the ability to communicate adequately to complete required forms and reports of visits, to follow verbal/written instructions;
- Have the ability to communicate effectively and cooperatively;
- Have the ability to provide services according to a plan of care;
- Be willing to accept supervision;
- Have successfully completed applicable training from a qualified provider agency or from the Indiana Division of Disability, Aging and Rehabilitative Services, or have previous experience as an aide in a home health agency, hospital, long-term care facility, or experience serving people with developmental disabilities;
- Have current Cardiopulmonary Resuscitation certification and first aid training;
- Be in adequate physical health to perform the job tasks required;
- Be free from communicable diseases with negative tuberculosis test or chest X-ray within 30 days prior to beginning service;

- Have an interest in and empathy for persons with developmental disabilities;
- Have interpersonal skills necessary to work productively with consumers;
- Criminal background check shows no history of;
  a) Abuse or fraud in any setting;
  b) Substantial and/or repeated violations in the operation of a residential or health care facility;
  c) Conviction of a crime related to the disabled population; or
  d) Substantial and/or repeated violations in the care of dependent persons;
- Be in compliance with 460 IAC 6.

5.2 Independence Assistance Services (IAS)

The following provider types may become certified as Independence Assistance Services providers under the Autism Waiver:

- Community developmental disabilities agencies, programs, or individuals approved under IC 12-11-1.1;
- Licensed home health agencies per IC16-27-1.

Providers certified to provide Residential Habilitation and Support may be automatically certified to provide Independence Assistance Services. A request for certification must be made to Provider Relations, Bureau of Developmental Disabilities Services.

Staff of agencies and individual practitioners must meet all of the following requirements:

- Be at least 18 years of age;
- Demonstrate the ability to communicate adequately to complete required forms and reports of visits, to follow verbal/written instructions;
- Have the ability to communicate effectively and cooperatively;
- Have the ability to provide services according to a plan of care;
- Be willing to accept supervision;
- Have successfully completed applicable training from a qualified provider agency or from the Indiana Division of Disability, Aging and Rehabilitative Services, or have previous experience as an aide in a home health agency, hospital, long-term care facility, or experience serving people with developmental disabilities;

- Have current Cardiopulmonary Resuscitation certification and first aid training;
- Be in adequate physical health to perform the job tasks required;
- Be free from communicable diseases with negative tuberculosis test or chest X-ray within 30 days prior to beginning service;
- Have an interest in and empathy for persons with developmental disabilities;
- Have interpersonal skills necessary to work productively with consumers;
- Criminal background check shows no history of;
  e) Abuse or fraud in any setting;
  f) Substantial and/or repeated violations in the operation of a residential or health care facility;
  g) Conviction of a crime related to the disabled population; or
  h) Substantial and/or repeated violations in the care of dependent persons;
- Be in compliance with 460 IAC 6.

5.3 Community Educational/Therapeutic Activities (CETA)

Residential Habilitation and Support and Community Habilitation and Participation providers are automatically approved to provide Community Educational/Therapeutic Activities. These providers may also serve as the Fiscal Intermediaries for allowable Community Educational/Therapeutic Activities provided by other generic community providers. Providers must be in compliance with 460 IAC 6.

5.4 Respite Care

The following provider types may be certified to provide Respite Care under the DD Waiver:

- Community developmental disabilities agencies, programs and individuals per IC 12-11-1.1;
- Individuals approved under IC12-11-1.1;
- Licensed home health agencies per IC 16-27-1;
- Individual RNs, LPNs, home health aides;
- Non-private specialized residential settings approved by the Indiana Bureau of Developmental Disabilities Services.

Staff of agencies, individual practitioners and family members must meet all of the following requirements:

- A home health aide, licensed practical nurse (LPN), or a registered nurse (RN) employed by a licensed home health agency;
- A home health aide registered under IC 16-27-1.5;
- An LPN licensed under IC 25-23-1-12;
- An RN licensed under IC 25-23-1;
- An agent of a respite care provider agency approved by the Indiana Bureau of Developmental Disabilities Services;
- An individual selected by the service recipient and/or their representative that meets the personnel criteria below.

Individual providers must be:

- Be at least 18 years of age;
- Demonstrate the ability to communicate adequately to complete required forms and reports and to follow written directions;
- Be skilled in the type of service to be provided;
- Be free of physical limitations which interfere with job performance;
- Be free of communicable diseases with negative tuberculosis test or chest X-ray with 30 days prior to beginning services;
- Have good communication and interpersonal skills and the ability to deal effectively, assertively, and cooperatively with a variety of people;
- Have the ability to provide services according to a plan of care;
- Have received training in the needs of the person who will be provided the service;
- Be willing to accept training and supervision;
- Criminal background check shows no history of
  a) Abuse or fraud in any setting;
  b) Substantial and/or repeated violations in the care of disabled persons;
  c) Conviction of a crime related to the disabled population; or
  d) Substantial an/or repeated violations in the operation of a residential or health care facility;
- Have current CPR certification and first aid training;
- Have competed any applicable training provided by the Indiana Division of Disability, Aging, and Rehabilitative Services when available. (This is not a requirement for individuals who otherwise qualify to provide services to a family member.);
- Individual practitioners providing Respite Care will be monitored by either the case manager or a qualified agency;
- Be in compliance with 460 IAC 6.

5.5 Prevocational Services

Prevocational Services are provided by Community Developmental Disabilities Agencies under IC 12-11-1.1.

Individual personnel qualifications:

- Be at least 18 years of age;
- Have the ability to read and write adequately to compete required forms and reports of visits/services, to follow verbal/written instructions;
- Have the ability to communicate effectively and cooperatively;
- Have the ability to provide services according to a plan of care;
- Be willing to accept supervision;
- Have successfully completed applicable training from a qualified provider agency or from the Indiana Division of Disability, Aging, and Rehabilitative Services, or have previous experience as an aide in a home health agency, hospital, long-term care facility, or experience serving people with developmental disabilities;
- Have current CPR certification and first aid training;
- Be in adequate physical health to perform the job tasks required;
- Be free from communicable diseases with negative TB test or chest X-ray within 30 days prior to beginning service;
- Have an interest in and empathy for persons with developmental disabilities;
- Have interpersonal skills necessary to work productively with consumers;
- Criminal background check shows no history of:
  a) Abuse or fraud in any setting;
  b) Substantial and/or repeated violations in the operation of a residential or health care facility;
  c) Conviction of a crime related to the disabled population; or
  d) Substantial and/or repeated violations in the care of dependent persons;
- Be in compliance with 460 IAC 6.

5.6 Supported Employment Follow-Along

Supported employment services are provided by Community Developmental Disabilities Agencies under IC 12-11-1.1 or Community Mental Health Centers under IC 12-25-1.

Individual personnel qualifications:

- Be at least 18 years of age;
- Have the ability to read and write adequately to compete required forms and reports of visits/services, to follow verbal/written instructions;
- Have the ability to communicate effectively and cooperatively;
- Have the ability to provide services according to a plan of care;
- Be willing to accept supervision;
- Have successfully completed applicable training from a qualified provider agency or from the Indiana Division of Disability, Aging, and Rehabilitative Services, or have previous experience as an aide in a home health agency, hospital, long-term care facility, or experience serving people with developmental disabilities;
- Have current CPR certification and first aid training;
- Be in adequate physical health to perform the job tasks required;
- Be free from communicable diseases with negative TB test or chest X-ray within 30 days prior to beginning service;
- Have an interest in and empathy for persons with developmental disabilities;
- Have interpersonal skills necessary to work productively with consumers;
- Criminal background check shows no history of:
  e) Abuse or fraud in any setting;
  f) Substantial and/or repeated violations in the operation of a residential or health care facility;
  g) Conviction of a crime related to the disabled population; or
  h) Substantial and/or repeated violations in the care of dependent persons
- Be in compliance with 460 IAC 6.

5.7 Health Care Coordination

Health Care Coordination is provided by a RN or LPN licensed under IC 25-23-1.

5.8 Family and Caregiver Training

Family and Caregiver Training may be provided by individuals, agencies, or educational institutions that have demonstrated expertise in the topic of the training identified in the Individualized Support Plan. Family and Caregiver Training may be provided through seminars, courses, and conferences organized by agencies or educational institutions. Individual training may also be provided by practitioners with experience in or demonstrated knowledge of

the training topic such as psychologists, teachers, social workers, medical personnel including home health aides, attendant care and personal assistance providers, therapists, educators and providers of other services such as day, vocational, and residential habilitation.

The following provider types may be authorized to provide Family and Caregiver Training to waiver recipients;

- Qualified staff of educational institutions;
- Qualified staff of home health agencies licensed under IC 16-27-1;
- Programs, agencies, individuals approved by the Bureau of Developmental Disabilities Services under IC 12-11-1.1;
- Qualified staff of community mental health centers under IC 12-25;
- Qualified staff of public health/human services agencies;
- Qualified staff of hospitals, clinics, or other agencies and organizations;
- Qualified individual providers.

Qualified individual practitioners include licensed personnel such as RNs, LPNs, psychologists, speech therapists, occupational therapists, and physical therapists. Individual non-licensed practitioners may qualify to provide services if they have the education, training, or experience directly related to the specified needs of the individual as described in the Individualized Support Plan. Individual practitioners will be supervised by the client/guardian and case manager.

Family and Caregiver Training services are to be billed through a Fiscal Intermediary, which at this time, includes providers certified for Residential Habilitation and Support or Community Habilitation and Participation.

5.9 Physical Therapy

Physical therapy must be provided by a licensed physical therapist or a physical therapist's assistant under the direct supervision of a physical therapist or physician as defined at IC 25-27-1. All providers must be in compliance with 460 IAC 6.

5.10 Occupational Therapy

Occupational therapy must be planned and directed (and may be delivered) by an occupational therapist licensed under IC 25-23.5-1. An occupational therapy assistant (IC 25-23.5-1-6) under the direct supervision of an occupational therapist, or an occupational therapy aide (IC 25-23.5-1-5.5) under the direct supervision of an occupational therapy assistant or occupational therapist may assist in the delivery of occupational therapy. All providers must be in compliance with 460 IAC 6.

5.11 Speech/Language Therapy

Speech/language therapy must be provided by a speech-language pathologist, licensed under IC 25-35.6-1 or a speech/language pathology aide (IC 25-35.6-1-2) under the direct supervision of a licensed language/speech pathologist. All providers must be in compliance with 460 IAC 6.

5.12 Recreational Therapy

To provide recreational therapy, individuals must hold a Bachelor's degree in therapeutic recreation, or in recreation with a concentration in therapeutic recreation and be certified by the National Council for Therapeutic Recreation Certification. All providers must be in compliance with 460 IAC 6.

5.13 Music Therapy

Music therapists must be certified by the National Association of Music Therapists. All providers must be in compliance with 460 IAC 6.

5.14 Psychological Therapy

Psychological therapy must be provided by a psychologist licensed under IC 25-33-1-1.1, or a certified marriage/family therapist who is supervised by a licensed psychologist, or a certified social worker/certified clinical social worker who is supervised by a licensed psychologist. All providers must be in compliance with 460 IAC 6.

5.15 Nutritional Counseling

Nutritional counseling must be provided by a dietitian certified under IC 25-14.5-1. All providers must be in compliance with 460 IAC 6.

5.16 Enhanced Dental Services

Dental services are provided by a dentist licensed under IC 12-14-1. All providers must be in compliance with 460 IAC 6.

5.17 Behavior Management/Crisis Intervention

Behavior management providers must be:

Level 1 Clinicians:

- A Doctoral level Psychologist with HSPP license in Indiana. HSPP is defined in IC 25-33-1; or

Level 2 Clinicians: (oversight by a Level 1 Clinician is required):

- A MA level graduate with a degree in Psychology, Special Education or Social Work; or
- A BA level clinician who was employed as a Behavioral Consultant by a certified provider on or before 9/30/2001, and is making reasonable progress toward a qualifying Master's degree to be completed by12/31/2006.

Oversight is defined as assistance with the direction of the behavior plan, review of the behavior plan (including review signature), and review of the application of the particular procedures and their outcomes by the Level 1 Clinician at least every 90 days. This process should take into consideration the needs, competencies, expectations, and philosophies of the Level 1 and Level 2 Clinicians. The result should be the professional growth and development of both clinicians and optimal service to the consumer.

All Clinicians providing Behavior Management supports are required to:

- obtain annually a minimum of 10 CEU's related to the practice of behavioral support:
  (a) from a Category 1 sponsor as provided in 868 IAC 1.1-15; or
  (b) as provided by the BDDS behavior management support curriculum list; **or**

- be enrolled in a Master's level program in psychology, special education, or social work; or a Doctoral program in psychology.

All behavioral support services providers must certify, if approved, that Level 1 clinician behavioral support services or Level 2 clinician behavioral support services will be provided using only persons who meet the qualifications as defined in 460 IAC 6-5-4. Individuals implementing Level 2 behavioral services must be supervised by a Level 1 Clinician.

5.18 Applied Behavior Analysis (ABA)

Qualified Providers:

Treatment teams that include a lead therapist who is a Medicaid certified:

- Psychologist licensed under IC 25-33; or
- Psychiatrist licensed under IC 25-22.5.

Licensed psychologists or psychiatrists (lead therapists) must have:

- completed 1,500 hours of training or supervised experience in the application of Applied Behavior Analysis (ABA) or an equivalent behavior modification theory for children with a pervasive developmental disorder; and
- at least two (2) years experience as an independent practitioner and as a supervisor of less experienced clinicians.

The lead therapist assumes a direct role in training and supervising the care of the individual or supervises a senior therapist who is a Medicaid certified:

- Psychotherapy provider who has at least 400 hours of training or supervised experience in the use of ABA or an equivalent behavior modification program for children with an autistic disorder, Asperger's disorder, or pervasive developmental disorder in addition to, or as part of 3,000 hours of training/supervision; OR
- Has a Bachelor's degree in a human services discipline and at least 2,000 hours of training or supervised experience in the use of ABA or an equivalent behavior modification program for children with an autistic disorder, Asperger's disorder, or pervasive developmental disorder.

Line staff who work under the supervision of the lead therapist and senior therapist must:

- Be in at least the second year of college and have obtained at least 30 hours of experience utilizing intensive behavioral treatment with children with autism or at least 160 hours working in any setting with children with autism; OR
- Be at least 18 years old and a high school graduate who has received 2,000 hours of training or supervised experience in the application of ABA or equivalent behavior modification program in a setting with children with autism.

Other standards:

- All staff should be recruited by the lead therapist and the patient's family with consideration given to background checks and compatibility.

5.19 Environmental Modifications, Specialized Medical Equipment and Supplies, Personal Emergency Response Systems, and Specialized Medical Equipment and Supplies Assessment/Inspection/Training

Qualified providers may be:

Licensed (where applicable)/certified housing contractor;

- Plumber licensed under IC 25-28.5-1;
- Electrician;
- Architect licensed under IC 25-4-1-2;
- Rehabilitation engineer;
  - An Associate's Degree in architectural drafting or 2 years experience in architectural drafting under the supervision of a degreed draftsman; and
  - A minimum of one year experience working with physically disabled individuals on accessibility and adaptive equipment needs for the purpose of maximizing their safety and independence;
- Licensed physician, nurse, OT, PT, ST, Audiologist;
- Home health care and medical equipment suppliers/retailers;
- Hearing aid dealers under IC 25-20-1-1; or
- Individuals or businesses known to be in the business of vehicle modification.

Other standards:

- Compliance with applicable federal/state/local requirements for licensure and/or certification;

- Services must be in compliance with federal/state/local codes relative to the type of modification made or assistive device provided;
- Working knowledge of ADA regulations as they apply to structural and individual safety;
- Bonding/liability insurance if applicable; or
- Providers that supply a service for a particular individual, may not perform the assessment/write specifications, and/or inspect the service for that individual.
- Compliance with 460 IAC 6.

All Environmental Modifications and Specialized Medical Equipment and Supplies shall be warranted for at least ninety (90) days.

5.20 Transportation

The following provider types may be certified to provide transportation services to waiver recipients:

- Community developmental disabilities provider agencies approved by the Bureau of Developmental Disabilities Services under IC 12-11-1.1;
- Community Mental Health Centers per IC 12-25;
- Licensed child care centers per IC 12-17-2-4;
- Qualified public and private carriers per IC 9-24-1-3; and
- Qualified individuals.

Individual personnel providing transportation must meet the following requirements:

- Have a valid Indiana driver's license appropriate to the vehicle being driven;
- Be at least 18 years of age;
- Communicate adequately to complete required forms and follow instructions;
- Have no significant driving violations i.e., repeated speeding citations, license suspensions, reckless driving, etc.;
- Criminal background check shows no history of abuse, fraud, substantial, or repeated violations in the care of disabled persons, conviction of a crime related to the disabled population or conviction of a violent crime;
- Have auto insurance, including liability insurance; and
- Have properly maintained vehicles.
- Be in compliance with 460 IAC 6.

5.21 Driver Services (Transportation Supports)

Agencies certified to provide Transportation services for the Waiver may also be certified to provide Driver services. Additional requirements include:

- Vehicles owned/operated by the provider agency must be in good repair, with inspection by a qualified mechanic at least every 6 months;
- Agencies must maintain insurance, including liability insurance, for all agency owned/operated vehicles;
- Reimbursement is available when the driver is a staff member who is transporting the individual to sites specified in the Individualized Support Plan;
- Reimbursement is not available when the driver is not an employee (i.e., staff member) of the agency provider of transportation services;
- Driver services must be documented in agency files.

Staff who will be driving consumers shall meet the following requirements:

- At least 18 years of age;
- Be a high school graduate, or have a GED, or demonstrate the ability to read and write adequately to complete required forms and reports and to follow written directions;
- Have CPR certification and first aid training;
- Have a valid Indiana driver's license appropriate to the vehicle being driven;
- Be in adequate physical health to perform required tasks;
- Be free from communicable disease, with negative TB test or chest x-ray;
- Have an interest in and empathy for persons with developmental disabilities;
- Criminal background check shows no history of:
  - Abuse or fraud in any setting;
  - Substantial and/or repeated violations in the care of disabled persons;
  - Convicted of a crime related to the disabled population; or
  - Conviction of a violent crime;
- Bureau of Motor Vehicles check shows no history of significant driving violations, i.e., no repeated speeding citations, license suspensions, reckless driving, etc.;

- Possesses interpersonal skills necessary to work productively with consumers;
- Have successfully completed orientation with provider agency, in addition to Direct Care Staff training;
- Have auto insurance, including liability insurance;
- Have properly maintained vehicles; and
- Be in compliance with 460 IAC 6.

5.22 Adult Day Services

An Adult Day Service facility may be certified to provide services when it has been determined by DDARS that the facility meets the standards and guidelines established by DDARS in June 2001. All providers must be in compliance with 460 IAC 6.

5.23 Adult Foster Care

Qualified Provider Types:

- Community developmental disabilities residential provider agencies approved by the Indiana Bureau of Developmental Disabilities per IC 12-11-1.1.

Personnel Qualifications:

- Be at least 18 years of age;
- Be a high school graduate or have a GED and demonstrate the ability to communicate adequately to complete required forms and reports and to follow directions;
- Have successfully completed appropriate training;
- Be in adequate physical health to perform required tasks;
- Be free from communicable disease, with a negative TB test or chest X-ray within 30 days prior to beginning services;
- Have an interest in and empathy for persons with developmental disabilities;
- Criminal background check shows no history of:
  a) Abuse or fraud in any setting;
  b) Substantial and/or repeated violations in the care of disabled persons;
  c) Conviction of a crime related to the disabled population;
  d) Conviction of a violent crime;
  e) Substantial and/or repeated violations in the operation of a residential or health care facility;

- Possess interpersonal skills necessary to work productively and cooperatively with individuals;
- Be in compliance with 460 IAC 6.

5.24 Community Transition

Qualified providers include agencies, individuals, pest control companies, utility companies, retail providers, and property owners/management companies.

Pest Control providers must be licensed under IC 15-3-3.6. Pest control licensure will be verified locally by the planning team or residential service providers. Other generic providers must be approved by the planning team.

All providers must be in compliance with 460 IAC 6.

5.25 Person Centered Planning Facilitation

Qualified Provider Types:

- Community developmental disabilities provider agencies under IC 12-11-1.1;
- Individuals;
- Family members of persons 18 years of age and older.

Personnel Qualifications:

- Be at least 18 years of age;
- Have an interest in and empathy for persons with developmental disabilities;
- Have interpersonal skills necessary to work productively with consumers;
- Must have successfully completed DDARS approved training for Person Centered Planning;
- Criminal background check shows no history of:
  a) Abuse or fraud in any setting;
  b) Substantial and/or repeated violations in the operation of a residential or health care facility;
  c) Conviction of a crime related to the disabled population;
  d) Substantial and/or repeated violations in the care of dependent persons.
- Be in compliance with 460 IAC 6.

PCP Facilitators are reimbursed only for individuals who do not choose the Targeted Case Manager as the PCP Facilitator.

5.26 Individual, Independent (non-agency based) Providers

Any individual providing a service or support must either have or receive training commensurate with the service or support to be delivered. For professional services under skilled services, the individuals must also meet any applicable state licensing or certification requirements.

For services that do not require licensure or certification, the planning team, including the individual, guardian, case manager, and other individuals and professional as are appropriate, will assess the skills of potential individual providers. The team will decide, and assure that the individual has the experience, skills, training and knowledge appropriate to the person and the type of support or services being delivered. This standard is intended to be used with providers of services such as homemaker, chore services, or individuals providing support for community-based socialization and recreation services.

5.27 Parents/Family Members as Service Providers

A parent or family member* (excluding a spouse) or legal guardian may provide and be reimbursed for waiver service(s) (including those living in the same home) if all of the following are met:

- The individual receiving services is at least 18 years of age;
- The parent, or family member is employed by an agency that is certified to provide care under the waiver;
- The parent or family member meets appropriate provider standards for the service(s) being provided;
- The decision for the parent or family member to provide services is part of the Person Centered Planning Process, which indicates that the parent or family member is the best choice of providers;
- There is adequate justification as to why the parent or family member is providing service;
- The decision for a parent or family member to provide services is evaluated periodically to determine if it continues to be in the best interest of the individual;
- Payment is made only in return for specific services rendered; and

* Family member is defined as someone related by blood or by marriage to any degree, excluding spouses.

- The services must be one-on-one with the individual. The parent or family member may not be responsible for others, including their (other) children, nor engaged in other activities while providing services.

  Parents/family members may provide services to minor children (under age 18) or spouses for extraordinary services requiring specialized skills, such as physical therapy or skilled nursing, which such people are not legally obligated to provide. All of the conditions listed above must be met with the exception of the age of the individual receiving services. Legal guardians of children under 18 may not receive payment for skilled or unskilled services. Parents/family members are not permitted to provide services under Adult Foster Care.

6. Fiscal Intermediaries/Rates

6.1 Fiscal Intermediaries

There are three services under the Autism Waiver that are typically reimbursed through Fiscal Intermediaries. They are:

- Community Educational and Therapeutic Activity (CETA);
- Family and Caregiver Training; and
- Rent and Food Expenses of Unrelated Live-In Caregiver.

In addition, other services may include the use of a Fiscal Intermediary to bill for some services for the individual and a provider that also bills for services it directly provides. They are:

- Community Transition;
- Person Centered Plan/Individualized Support Plan Facilitation; and
- Transportation.

In order to keep these services flexible and responsive to individual needs, a certified Residential Habilitation and Support provider or a certified Community Habilitation and Support provider will act as the Fiscal Intermediary by paying the direct service provider (camp, horseback therapy, community college, bus company, neighbor, etc.) and billing Medicaid on a standard HCFA Form 1500 for the actual reimbursable expense per activity.

These services must be based upon the Individualized Support Plan and included in an approved Plan of Care/ Cost Comparison Budget in advance of their provision.

See sections 4 and 5 for further information regarding definitions and qualifications for these services.

6.2 Rates (Attached)

Autism Waiver				
Service	**Procedure Code**	**Unit**	**Rate**	
Adult Day Services Level 1 (½ day)	Z5114	.5 day	$20.90	
Adult Day Services Level 1 (¼ hour)	Z5115	.25 hour	$1.31	
Adult Day Services Level 2 (½ day)	Z5116	.5 day	$27.43	
Adult Day Services Level 2 (¼ hour)	Z5117	.25 hour	$1.71	
Adult Day Services Level 3 (½ day)	Z5118	.5 day	$32.66	
Adult Day Services Level 3 (¼ hour)	Z5119	.25 hour	$2.04	
Adult Day Services Transportation - One way trip	Z5120	1 way trip	$16.25	
Adult Foster Care – Level 1	Z5181	1 month	$1,500.00	
Adult Foster Care – Level 2	Z5182	1 month	$2,250.00	
Adult Foster Care – Level 3	Z5183	1 month	$3,000.00	
Behavior Management and Behavior Management HSPP	Z5726	.25 hour	$17.38	
Community Educational/Therapeutic Activity	Z5158	1 unit		One unit is actual cost up to $2,000 per rolling calendar year
Community Habilitation and Participation - Community Based Individual	Z5163	1 hour	$27.58	
Community Habilitation and Participation - Community Based Group	Z5164	1 hour	$6.68	
Community Habilitation and Participation - Facility Based Individual	Z5165	1 hour	$27.58	Maximum one hour per day
Community Habilitation and Participation - Facility Based Group	Z5166	1 hour	$5.34	
Community Transition	Z5186	1 unit		One unit is actual cost up to $1,000 per lifetime.
Crisis Intervention	Z5177	1 day		Rate established by DDARS with provider
Driver (agency) - 1 person	Z5173	1 hour	$15.88	

Driver (agency) - 2-4 people	Z5174	1 hour	$5.03	
Driver (agency) - 5-8 people	Z5175	1 hour	$2.38	
Driver (agency) - 9 or more	Z5176	1 hour	$1.35	
Environmental Modifications/Specialized Medical Equipment Supplies-Assessment/Inspection/Training	Z5144	.25 hour	$17.99	
Environmental Modifications - Initial	X3019	1 unit		One unit is actual cost up to $15,000 per lifetime
Environmental Modifications - Maintenance	X3020	1 unit		One unit is actual cost up to $500 per rolling calendar year
Family and Caregiver Training	Z5024	1 unit		One unit is actual cost up to $2,000 per rolling calendar year
Health Care Coordination	Z5143	1 hour	$48.06	
Independence Assistance Services – Tier 1	Z5184	1 month	$750.00	
Independence Assistance Services – Tier 2	Z5185	1 month	$1,000.00	
Music Therapy - Individual	Z5156	.25 hour	$10.78	
Nutritional Counseling	Z5149	.25 hour	$14.47	
Occupational Therapy (HHA)	X3015	.25 hour	$17.99	
Occupational Therapy (IDDARS-Hab Agency/ Other)	X3016	.25 hour	$17.99	
PCP/ISP Facilitation – Initial	Z5187	1 unit	$400.00	Maximum 2 per rolling calendar year
PCP/ISP Facilitation - Ongoing	Z5188	1 unit	$100.00	Maximum 4 per rolling calendar year
Personal Emergency Response System - Monthly Charge	Z5620	1 month	$52.07	
Personal Emergency Response System - Installation	Z5699	1 unit	$52.07	
Physical Therapy (HHA)	X3017	.25 hour	$18.12	
Physical Therapy (IDDARS-Hab Agency/Other)	X3018	.25 hour	$18.12	
Pre-Vocational Services	X3011	.25 hour	$1.20	
Psychological Therapy - Individual	Z5146	.25 hour	$15.45	
Psychological Therapy - Family	Z5147	.25 hour	$17.27	

Psychological Therapy - Group	Z5148	.25 hour	$4.81	
Recreational Therapy -Individual	Z5157	.25 hour	$10.78	
Rent/Food Expenses of Unrelated Live-In Caregiver	Z5160	1 month	$545.00	
Residential Habilitation and Support Fewer than 35 hours per week	Z5170	1 hour	$19.49	
Residential Habilitation and Support Fewer than 35 hours per week - QMRP	Z5171	1 hour	$24.49	Maximum 10 hours per month
Residential Habilitation and Support 35+ hours per week	Z5172	1 hour	$17.59	
Residential Habilitation and Support Daily Rate	Z5178	1 day		
Respite - Personal Assistance (HHA/IDDARS-Hab Agency)	Z5606	1 hour	$16.00	
Respite - Home Health Aide (HHA)	Z5607	1 hour	$16.00	
Respite - LPN (HHA)	Z5608	1 hour	$23.64	
Respite - RN (HHA)	Z5609	1 hour	$31.14	
Respite - Personal Assistance (Non-Agency)	Z5655	1 hour	$9.79	
Respite - Group Setting	Z5951	1 hour	$5.99	
Specialized Medical Equipment and Supplies-Initial	X3013	1 unit		1 unit is actual cost
Specialized Medical Equipment and Supplies-Maint.	X3014	1 unit		1 unit is actual cost up to $500.00 per rolling calendar year
Speech and Language Therapy (HHA)	Z5708	.25 hour	$18.12	
Speech and Language Therapy (IDDARS-Hab Agency/Other)	Z5715	.25 hour	$18.12	
Supported Employment	X3012	.25 hour	$9.17	
Transportation	Z5142	1 month	$300.00 max.	

7. Application and Start of Waiver Services

7.1 Request for Application

An individual or his/her guardian may apply for the Medicaid Waiver for Persons with Autism through the local Bureau of Developmental Disabilities Services (BDDS) office or participating Area Agency on Aging (AAA). Individuals (or their guardians) have the right to apply without question or delay.

To apply for the Autism Waiver, the individual or guardian must complete, sign, and date an Application for Long-Term Care Services *(State Form 45943)*. (The time of day must also be noted on the application.) An individual who has not already applied for Autism Waiver services may also need to complete, sign, and date a DDARS Referral and Application (*State Form 10057*). Other individual or agency representatives may assist the individual or guardian in completing the application form and forward it to the BDDS or AAA (where applicable) office serving the county in which the individual currently resides. (The application may be submitted in person, by mail or FAX.) When an application for long-term care is received by the participating AAA or BDDS office for a person with a developmental disability, it is to be viewed also as an application for Targeted Case Management.*

Within 14 days of receiving the Waiver application, the BDDS or AAA staff must contact the individual and/or his/her guardian and discuss the process for determining eligibility for the waiver (diagnosis of Autism, documentation of a developmental disability, Medicaid eligibility, and level of care) and arrange with the client/guardian/advocate to obtain information necessary for the eligibility determination. If the applicant is not a Medicaid recipient, he/she will be immediately referred to the local Division of Family and Children to apply for Medicaid.

7.2 Waiting List Level of Care Determination

To be placed on the waiting list for the Autism Waiver an individual must meet preliminary level of care required for placement in an Intermediate Care Facility for the Mentally Retarded (or Developmentally Disabled) (ICF/MR), as well as have the diagnosis of Autism. Other diagnoses on the Autism Spectrum do not apply. Children who have not yet reached their

* All references to case managers/case management in this manual are "Targeted" case management services provided under the Medicaid State plan to individuals with developmental disabilities.

6th birthday may remain on the waiting list with a completed Statement of Eligibility (State Form 13209) without a level of care determination.

To complete a preliminary level of care determination, the BDDS Service Coordinator or the case manager (or a QMRP when the case manager is not a QMRP), must obtain and review the following:

a) A Statement of Eligibility (State Form 13209) completed by the Bureau of Developmental Disabilities Services;
b) A Developmental Disabilities Profile (DDP) completed by a Targeted Case Manager within the past year for an individual who has reached his 6th birthday; or
c) Psychological, social, medical and additional records necessary to have a current and valid reflection of the individual. If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained through the local BDDS-contracted diagnostic and evaluation (D&E) team.

If the applicant meets level of care, a Data Entry Worksheet is completed in INsite or DART and the level of care determination date must be entered into the DART or INsite database and transmitted to the DDARS database.

Starting February 1, 2003, all individuals who are added to the waiting list will need to sign a document that the waiting list is "first come, first served" and that they agree to the following terms (this form may be printed from the INsite database):

- They must notify the wait list agency/manager of any change in contact information;
- This specific contact information will be used to contact them when they are targeted;
- If they wish to withdraw from the list, they need to contact the wait list agency/manager;
- Once an individual is targeted, he/she will be given 30-days to respond. Failure to respond will result in the waiver slot being offered to the individual next in line on the waiting list; however, the individual's name will remain on the list and will not be re-targeted until slots are again available in the next waiver year (January 1).

If a case manager other than a BDDS Service Coordinator determines that the applicant may not meet ICF/MR level of care, the case manager must notify the local BDDS Service Coordinator. The BDDS Service Coordinator must review the documents and make a level of care

determination. If the Service Coordinator determines that the applicant does not meet ICF/MR level of care, the Service Coordinator must immediately:

a) Send a denial determination letter from BDDS enumerating the specific reason(s) for the denial to the individual and/or guardian;
b) Complete a Notice of Action form (*HCBS Form 5*) with the following statement:

   As required under 42 CFR 441.301(b)(1)(iii)(C) and the approved Autism Waiver, you do not require the Level of Care provided in an ICF/MR in the absence of the waiver and community-based services.

c) Provide a copy of the completed Notice of Action form with the original BDDS denial determination letter as an attachment, its accompanying Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to the individual or guardian.
d) Complete a Data Entry Worksheet *(HCBS DE T/D)*, enter into the database, and transmit to DDARS.

The case manager should discuss other service options with the individual and guardian. An individual who does not meet level of care criteria and consequently, is not eligible for the Autism Waiver, may still be eligible for Targeted Case Management if he/she is a Medicaid recipient and is determined eligible for developmental disabled services according to the State definition.

If the individual and/or guardian appeals the denial, and the denial is overturned, the individual will be placed back on the waiting list with the original application date and time and the LOC decision will be updated in DART and transmitted to DDARS.

7.3 Waiting List

An individual will remain on the statewide waiting list until a vacancy or "slot" becomes available on the waiver. Home and Community-Based Waiver programs limit the number of unduplicated recipients who may be served on the waiver each year.

The Autism Waiver waiting list is a single state-wide first come, first served (based on date of application) list. Once an applicant has applied for the Autism Waiver, his or her name remains on the statewide Autism Waiver waiting list with the same date of application regardless of where

he or she resides within the State. Moving from one BDDS District to another has no impact on position number for this waiting list.

7.3.1. Waiting List Special Considerations

If an individual who has applied for the waiver moves into or out of a facility while on the waiting list, the original application date will continue to be used in determining his/her place on the waiting list.

7.4 Waiver Slot Assignment

A slot represents an unduplicated recipient for the waiver year. Therefore, once that finite number of recipients is reached in the waiver year, a slot does not become available until the beginning of the next waiver year (January 1 for the Autism Waiver), even if someone vacates a slot in the middle of the waiver year.

As funding becomes available for additional waiver slots and prior to the start of the new waiver year (January 1), BDDS will review the statewide waiting list, and "target" the next individuals on the waiting list to fill the available waiver slots. The individuals targeted to fill the available slots on the waiver are the individuals who have the oldest waiver application dates of all individuals on the single waiting list.

- Slots assigned to targeted individuals are based on position on the statewide waiting list.

7.5 Processing "Targeted" Individuals

When a waiver slot becomes available, the next individual on the waiver waiting list will be "targeted" to fill the slot, and the target date is entered into the INsite database by the Central Office Service Coordinator. The Central Office Service Coordinator will:

a) Notify in writing (Registered Mail, Return Receipt) the individual and/or guardian that the individual has been targeted for an Autism Waiver slot; and
b) Notify the appropriate BDDS district Service Coordinator that the individual has been targeted.

Within 14 days of the target date, the BDDS district Service Coordinator will make contact with the individual and/or his/her guardian to follow-up on the letter.

Within 30 days of receipt of the notice, the individual and/or guardian must sign a statement that:

1) The individual/guardian accepts the slot and will pursue eligibility determination for waiver services;
2) The individual/guardian wishes to decline the slot at this time but wishes to remain on the waiting list with the original application date, thus being placed at the top of the waiting list for the next group of targeted waivers; or
3) The individual/guardian declines the Autism Waiver slot and requests to be removed from the waiting list for the Autism waiver.
    - If an individual is removed from the waiting list, the BDDS Service Coordinator must complete a Notice of Action form (HCBS Form 5) and provide a copy of the form, its accompanying Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to the individual or guardian.
    - A Data Entry Worksheet (HCBS DE T/D) must be completed, entered into the database, and transmitted to DDARS.

A copy of the signed statement is to be sent to the BDDS office designated on the form.

If the individual and/or guardian chooses to accept the slot and is a current Medicaid recipient, the BDDS Service Coordinator will assist the individual in choosing a Targeted Case Manager if he/she does not already have one, and the Targeted Case Manager or BDDS Service Coordinator will:

a) Submit the Request for Information *(HCBS Form 6)* to the local DFC office to obtain Medicaid eligibility information including "spend-down" (or "liability") amount. (The DFC office is to complete the request within 7 calendar days of receipt and return it to the Targeted Case Manager or BDDS Service Coordinator); and
b) Notify the individual who will be responsible for gathering documents necessary to update the Level of Care.

7.6 Initial Level of Care Determination

An individual targeted for the Autism Waiver must meet the level of care required for placement in an Intermediate Care Facility for the Mentally Retarded (or Developmentally Disabled) (ICF/MR) and have the diagnosis of Autism (other diagnoses on the Autism Spectrum do not apply) to be eligible for community services through the Autism Waiver.

Initial level of care determinations for the Autism Waiver are to be made by:

a) An OMPP QMRP for:
   1) Children who have not reached their 6th birthday; or
   2) Individuals who have been identified by the Indiana Department of Health as W197 or W198 and have not been determined to meet ICF/MR level of care after the W197 or W198 determination by the Indiana Department of Health;
b) A BDDS Service Coordinator, or a BDDS QMRP if the Service Coordinator is not a QMRP for:
   1) Individuals whose determination is not required to be made by OMPP; and
   2) Who are not currently eligible for Ongoing Targeted Case Management; or
c) The Ongoing **Level 1** Targeted Case Manager (QMRP) for:
   1) Individuals whose determination is not required to be made by OMPP; and
   2) Who are currently eligible for Ongoing Targeted Case Management.

The case manager or BDDS Service Coordinator if the individual is not currently eligible for Ongoing Targeted Case Management must obtain the following information:

a) A Statement of Eligibility (State Form 13209) completed by the Bureau of Developmental Disabilities Services
b) A completed Medicaid Form 450B medical form. The form may be either:
   1) The 450B/QMRP form completed, signed and dated by a QMRP; or
   2) The 450B Physician Certification form completed, signed and dated by a physician
   The Medicaid Form 450B must have an attached physical examination signed and dated by a physician within the past year;
c) A Developmental Disabilities Profile (DDP) completed by a Targeted Case Manager within the past year if the individual has reached his 6th birthday;
d) An age-referenced comprehensive developmental assessment if the individual has not reached his 6th birthday;
e) Psychological, social, medical and additional records necessary to have a current and valid reflection of the individual. If collateral records are not available or are not a valid reflection of the

individual, additional assessments may be obtained through the local BDDS-contracted diagnostic and evaluation (D&E) team

When OMPP must make the level of care determination:

a) The Targeted Case Manager or BDDS Service Coordinator is to send the packet directly to OMPP. If the determination must be made by OMPP, a Transmittal for Medicaid Level of Care Eligibility (HCBS form 7) is completed by the QMRP. The QMRP must assure that the information is a current and valid reflection of the individual.

b) OMPP may request additional documentation from the case manager, BDDS, the individual, family, or providers to verify the accuracy of the DDP or developmental assessment.

c) Within five days of receiving the completed level of care packet, OMPP will enter the level of care determination on the Transmittal (form 7) and on the Form 450B and mail them directly to Targeted Case Manager or BDDS Service Coordinator who submitted the packet.

d) If level of care is denied, OMPP will also mail a Level of Care denial determination letter to the Targeted Case Manager or Service Coordinator enumerating the specific reason(s) for denial. The Targeted Case Manager or Service Coordinator if there is no Targeted Case Manager must immediately:
   - Send a copy of the denial letter from OMPP enumerating the specific reason(s) for the denial to the individual and/or guardian;
   - Complete a Notice of Action form (*HCBS Form 5*) with the following statement:

     As required under 42 CFR 441.301(b)(1)(iii)(C) and the approved Autism Waiver, you do not require the Level of Care provided in an ICF/MR in the absence of the waiver and community-based services.
   - Provide a copy of the completed Notice of Action form with the original OMPP denial determination letter as an attachment, its accompanying Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to the individual or guardian.
   - Complete a Data Entry Worksheet *(HCBS DE T/D)*, enter into the database, and transmit to DDARS.

When BDDS must make the level of care determination:

a) Within 5 days of receiving the completed packet the QMRP making the level of care determination must complete a *Level of Care Review Form* in the DART or INsite database.
b) BDDS will mail a letter to the Targeted Case Manager (or to the individual or guardian if the individual does not have a Targeted Case Manager) enumerating the specific reason(s) for the denial.
c) If the determination is that the applicant does not meet ICF/MR level of care and therefore is ineligible for services under the Autism Waiver, the Targeted Case Manager (or the Service Coordinator if the individual does not have a Targeted Case Manager) must immediately:
    - Send a copy of the denial letter from BDDS to the individual and/or guardian enumerating the specific reason(s) for the denial;
    - Complete a Notice of Action form (HCBS Form 5) with the following statement:

        As required under 42 CFR 441.301(b)(1)(iii)(C) and the approved Autism Waiver, you do not require the Level of Care provided in an ICF/MR in the absence of the waiver and community-based services.
    - Provide a copy of the completed Notice of Action form with the BDDS denial determination letter as an attachment, its accompanying Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to the individual or guardian.
    - Complete a Data Entry Worksheet *(HCBS DE T/D)*, enter into the database, and transmit to DDARS.

When the Targeted Case Manager makes the level of care determination:

- Within 5 calendar days of receiving the completed packet, the QMRP must complete a Level of Care Review Form in the Insite
- If the applicant meets level of care, the level of care determination date must be entered into the DART or INsite database and transmitted to the DDARS database.

If the determination is that the applicant may not meet ICF/MR level of care, the Targeted Case Manager must forward the packet to the BDDS Service Coordinator for review. ***Level of Care denials can only be made by OMPP or BDDS.***

The Targeted Case Manager may discuss other service options with the individual and guardian. An individual who does not meet level of care criteria and consequently, is not eligible for the Autism Waiver, may still be eligible for Targeted Case Management if he/she is a Medicaid recipient and developmentally disabled according to the State definition.

7.7 Initial Plan of Care and Cost Comparison Budget (POC/CCB) Development

If the individual is not already a current Medicaid recipient, the BDDS Service Coordinator is to complete a Notice of Action form (HCBS Form 5) and send it to the local DFC office with a request that the individual be determined eligible for Medicaid with a Waiver-eligible aid category (Aged, Blind, Low Income Families, Disabled, or Disabled Worker) and an effective date the same as or prior to the level of care approval date. The Medicaid eligibility date may be up to 90 days prior to the date the individual applies for Medicaid based on Medicaid rules.

If the individual has not already chosen an Ongoing Targeted Case Manager, the BDDS Service Coordinator is to assist the individual in choosing one.

The Targeted Case Manager is encouraged to develop and submit a *basic* plan of care for the individual in order to initiate waiver services and expedite utilization of the waiver slot, with the Person Centered Plan/Individualized Support Plan process to be completed within 90 days.

The Targeted Case Manager is responsible for facilitating the Person Centered Plan/Individualized Support Plan process with the individual, guardian, and additional participants who the individual may request. The individual may choose another person to facilitate the Person Centered Plan/Individualized Support Plan process if that individual meets the qualifications to do so (see Section 5).

The Targeted Case Manager develops an Initial POC/CCB based upon the Person Centered Planning/Individualized Support Plan process that includes the full range of appropriate services, delivered in a planned, coordinated, efficient, and effective manner. The POC/CCB includes the proposed annual start and end dates, Medicaid waiver services, Targeted Case Management and other Medicaid State plan services, other publicly funded services, and informal supports that the individual receives/will receive. Additionally, unmet needs and emergency back-up plans must be addressed by the Case Manager on the POC/CCB.

The Targeted Case Manager is responsible for coordinating the proposed waiver funds with any other proposed sources of public funding. Medicaid funding should be utilized first to fund services whenever possible. Waiver funding should be utilized before State line-item or CHOICE funding for comparable services. CHOICE funding is at the discretion of the Area Agencies on Aging.

The Targeted Case Manager must complete a Service Planner form that indicates the proposed waiver services to be provided during a "typical" week for the individual.

The POC/CCB must include a written explanation of the individual's need for the proposed services, the manner by which the services protect the individual's health and safety, the individual's needs that will not be met, and a description of emergency back-up plans.

If the cost of services on an individual's CCB exceeds $300 a day, the Targeted Case Manager must complete the “high cost comments” section of the CCB detailing explicitly the following issues (at least):

a) The need for 24-hour staff for the individual;
b) Identify what is needed by the individual to be healthy and safe in the community. (Strive to separate what is necessary to be healthy and safe, from what is desired by the individual, family, advocates, etc.)
c) Describe how the individual's needs drive the Service Planner and budget;
d) Identify from where the individual is being deinstitutionalized (or diverted);
e) Describe the reason for 1:1 staffing or other high levels of staff supervision;
f) Explain why the individual does not have housemate(s) and describe plans for the individual to have a housemate; and
g) List the specific steps being taken, including timeframes, to reduce the individual's behavioral, medical, or other issues that may be causing the need for high levels of services and funding.

The Targeted Case Manager must review the POC/CCB and Service Planner with the individual/guardian, and the individual/guardian must sign indicating acceptance of the POC/CCB. The individual/guardian must also be informed (and sign to document that he/she has been informed of):

a) The right to choose any certified waiver service provider when selecting waiver service providers, including the Targeted Case Manager; and
b) The right to choose between institutional placement and Home and Community-Based Waiver Services.

The Targeted Case Manager must enter the proposed POC/CCB and Service Planner into the INsite database and electronically transmit the information to the Waiver Specialist in DDARS.

Note: The POC/CCB and Service Planner may be developed during the level of care process if the level of care is being updated due to the length of time the individual was on the waiting list and there is a good indication that the individual will continue to meet level of care.

7.8 State Authorization of the Initial Plan of Care and Cost Comparison Budget (POC/CCB)

Within 7 calendar days of receipt of an approval from the Targeted Case Manager, the Waiver Specialist will review the POC/CCB and Service Planner and confirm the following:

a) The individual is a current Medicaid recipient within the category of Aged, Blind, Disabled, Low Income Families, or Disabled Worker;
b) The individual has a current ICF/MR level of care approval and a diagnosis of Autism for the waiver;
c) The individual has been targeted for an available waiver slot;
d) The individual's identified needs will be met and health and safety will be assured;
e) The costs are consistent with identified needs of the individual and the services to be provided;
f) That if the total cost of Medicaid waiver and regular Medicaid State plan services for the individual, exceeds the total costs of serving an individual with similar needs in an ICF/MR facility, the programmatic cost-effectiveness will be maintained;
g) The individual or guardian has signed, indicating acceptance of, the POC/CCB; signed that he/she has been offered choice of certified waiver service providers; and signed that he/she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Targeted Case Manager to assist in reviewing the packet. The Waiver Specialist may also request a review of the POC/CCB by the local BDDS District office.

If the Waiver Specialist denies the POC/CCB, a denial letter must be transmitted to the Targeted Case Manager and BDDS. Within 5 calendar days of receipt of the denial, the Targeted Case Manager must complete and provide a copy of a Notice of Action *(HCBS Form 5),* the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to deny to the individual/guardian. The Targeted Case Manager is to discuss other service options with the individual and guardian and the individual's name should be removed from the waiting list unless the individual or guardian files an appeal.

If the Waiver Specialist approves the POC/CCB, the approval letter is transmitted to the Targeted Case Manager and BDDS. The Targeted Case Manager is to notify the individual or guardian within 5 calendar days of receipt of the approval and provide a copy of the approval letter.

If the Waiver Specialist approves the POC/CCB pending Medicaid eligibility, disenrollment of a child from Hoosier Healthwise, level of care approval, facility discharge, or other reasons, the pending approval letter is to be transmitted to the case manager and BDDS. The Targeted Case Manager must notify the individual or guardian within 5 calendar days of receipt of the approval and provide a copy of the approval letter.

7.9 Initial Plan of Care Implementation

An individual cannot begin waiver services prior to the approval of the Initial POC/CCB by the Waiver Specialist. If the Waiver Specialist issues an approval letter, pending certain conditions being met, those conditions must be resolved prior to the start of the individual's waiver services.

If the individual's Medicaid eligibility is approved pending waiver approval, the Targeted Case Manager is to notify the local DFC caseworker when the waiver has been approved. The caseworker and Targeted Case Manager are to coordinate the Medicaid eligibility date and waiver start date. (If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the POC/CCB.)

If an individual is a Hoosier Healthwise or other Medicaid managed care program participant, the Targeted Case Manager must contact the local DFC caseworker to coordinate the managed care program stop date and waiver start date. Individuals receiving the Indiana Health Care Hospice benefit do not have to disenroll from this benefit to receive

waiver services that are not related to the terminal condition and are not duplicative of hospice care. The Targeted Case Manager and Managed Care Benefit Advocate must inform the individual's parent or guardian of his/her options to assure he/she makes an informed choice.

a) When the POC/ CCB is approved by the Waiver Specialist pending facility discharge, the waiver start date can be the same day that the individual is discharged form the facility.

Within 3 calendar days after the individual begins waiver services, the Targeted Case Manager must complete the Confirmation of Waiver Start form in the INsite database and electronically transmit it to the DDARS database.

When the Confirmation of Waiver Start form is received electronically by DDARS, an approval letter will be automatically transmitted back to the Targeted Case Manager. The period covered by the Initial POC/CCB will be from the effective date of the Confirmation form through the end date of the Initial POC/CCB that was previously approved by the Waiver Specialist.

When the Targeted Case Manager completes the Confirmation of Waiver Start form in the INsite database and electronically transmits it to the DDARS database, OMPP will also be notified to enter the individual's Waiver start information in the Indiana AIM database.

Within 3 calendar days of receiving the Initial POC/CCB approval letter, the Targeted Case Manager must print a Notice of Action form (*HCBS Form 5*) and sign it. The Targeted Case Manager must provide copies of the signed Notice of Action form and Addendum (containing information from the POC/CCB and Service Planner) to the individual/guardian and all of the individual's waiver service providers.

7.10 Authorization of Environmental Modifications and Specialized Medical Equipment and Supplies

Environmental modifications and Specialized Medical Equipment and Supplies (SMES), as specified in the Waiver, may be authorized when necessary to enable the individual to increase his or her ability to function in a home and community-based setting with independence and physical safety.

These services must be necessary to prevent or delay institutionalization as defined in the individual's POC/CCB.

Environmental modifications may be made only to an individual's permanent home or long-term leased residence and require permission of the landlord when applicable.

Reimbursement is not available for services that:

a) Are not allowable under current Medicaid Waiver guidelines;
b) Are available under the Medicaid State Plan as prior authorized services;
c) Are available under the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act, as amended;
d) Are not included in the individual's POC/CCB; or
e) Have not been authorized via a Request for Approval to Authorize Services *(Form BAIS 0014).*

The Targeted Case Manager must obtain a physician's order for environmental modifications or SMES prior to including the service in the individual's POC/CCB.

The Targeted Case Manager must obtain a Medicaid prior authorization review and denial of SMES before including them in the individual's POC/CCB.

Medicaid prior authorization review is not required for environmental modifications.

For an individual who will be moving from a facility, the Targeted Case Manager must indicate that the SMES will be used by the individual following discharge from the facility.

Notes:

a. If three bids cannot be obtained, due solely to a lack of qualified service providers in geographic proximity to the individual, the Targeted Case Manager must provide a written explanation as to why the three bids were not obtained.
b. Service bids must be in writing, itemize parts and materials and their costs, itemize labor items and their costs, and specify warranties on parts, materials and workmanship. Bids for environmental modifications must include drawings in sufficient detail to describe the modifications to the current home or environment of the individual.
c. The price to be authorized is the lowest price quotation, unless justified, such as when the higher price quotation costs less for maintenance, repair or replacement, more nearly meets the needs

of the individual, or provides greater safety, and is recommended for approval by the Targeted Case Manager.

d. Pursuant to 460 IAC6-21 and 460 IAC6-32, as amended, all environmental modifications and SMES shall be warranted for at least 90 days.

The Targeted Case Manager must complete, sign and date a Request for Approval to Authorize Services Form *(BAIS 0014)* and must enter the information into the INsite database. Thorough documentation supporting the Request for Approval to Authorize Services Form must be entered into the INsite database by the Targeted Case Manager.
The Targeted Case Manager must verify the receipt of the following at the time the Request for Approval to Authorize Services Form is electronically transmitted to the Autism Waiver Specialist:

a) Physician's order;
b) Medicaid prior authorization denial, when required;
c) Evaluation; and
d) Service bids, including written explanation when less than three bids are available, and statement that the environmental modification or SMES are warranted for at least 90 days.

All requests for environmental modifications and SMES must assure the following:

a) The modifications or SMES are allowable under current Medicaid Waiver guidelines;
b) Necessary and properly completed documentation accompanies the request; and
c) The request does not exceed the individual's lifetime caps for the service allowable under Medicaid Waiver guidelines.

The Waiver Specialist must indicate if the request is approved, approved with modifications, or denied on the Request for Approval to Authorize Services Form in the INsite database. Once the decision rendered information is entered into the INsite database by the Waiver Specialist, the Waiver Specialist's signature will then be electronically attached to the Request for Approval to Authorize Services Form in INsite and electronically transmitted back to the Targeted Case Manager.

The Targeted Case Manager must complete a Notice of Action and provide it to the individual or guardian and service provider. If the request

is denied, the case manager must notify the individual of his or her appeal rights.

The Targeted Case Manager must oversee and inspect the timely completion of the service, consistent with the evaluation and approved bid.
Upon completion of the service consistent with the approved bid, the Targeted Case Manager must sign and date the Request for Approval to Authorize Services Form, provide a copy of the form to the provider to submit with billing for the service, and enter the completion information into the INsite database.

After the completion information is entered into the INsite database, the Targeted Case Manager may print out a completed HCFA 1500 Form for the provider to sign and submit along with the completed Request for Approval to Authorize Services Form when billing for the service.

If the individual resides in a Medicaid-funded facility, the Targeted Case Manager may authorize the service provider to complete the service in advance of the individual's move if all of the following criteria are met:

a) The service must be necessary to enable the individual to move from the facility to home and community-based services;
b) The individual has been targeted for a Waiver slot and has a current level of care approval for the Waiver;
c) The Request for Approval to Authorize Services Form has been approved by the appropriate BDDS District Manager or Waiver Specialist;
d) The service has been included in the individual's approved POC/CCB; and
e) The Targeted Case Manager shall not sign and date the Request for Approval to Authorize Services Form indicating completion of the service prior to the individual's move from the facility and starting Medicaid Waiver-funded services.

7.11 Senate Bill 30 Children

Senate Bill 30 is a provision which allows parental income and resources to be disregarded when determining Medicaid eligibility for children under age 18 who are otherwise eligible for the Autism Waiver.

Identification of the children involved will be made by the Intake or Ongoing Targeted Case Manager. A Notice of Action *(HCBS Form 5*) will be sent to the child's local County DFC eligibility worker as an alert that

the child is undergoing the evaluation process for approval of waiver services. Upon receipt of this form, the DFC is to process the Medicaid case to the furthest extent possible without consideration of parents' income and resources pending receipt of verification of the waiver, and then notify the case manager that the child is eligible pending approval of the waiver.

For children who cannot have an active Medicaid case without the SB 30 Children Provision, the effective date of Medicaid and the effective date of the waiver must be coordinated between the DFC eligibility worker and Targeted Case Manager. Similarly, the effective date of a new or changed spend down under this provision must coincide with the effective date of the Waiver.

The exclusion of parental resources and income applies only as long as the child is approved for the Waiver. Parental deeming resumes beginning the month following the month in which the Waiver was discontinued for the child who continues to live with his or her parents, in accordance with timely notice requirements.

8. Monitoring and Continuation of Waiver Services

8.1 Compliance With Standards

All Waiver service providers, including Targeted Case Managers, must comply with all applicable DDARS standards, including but not limited to:

- 460 IAC 6 concerning supported living services and supports for individuals with a developmental disability, amended;
- Person Centered Planning and Individualized Support Plan guidelines, as revised;
- Incident Reporting guidelines, as revised; and
- BDDS and BQIS Waiver Bulletins.

At least every 90 days, the Targeted Case Manager must complete the Quarterly Review Checklist, enter the information in the INsite database and electronically transmit the information to the DDARS Waiver database.

If a dispute arises between or among providers, the dispute resolution process set out in 460 IAC 6-10-8, as amended, shall be implemented.

- The resolution of a dispute shall be designed to address an individual's needs.
- The parties to the dispute shall attempt to resolve the dispute informally through an exchange of information and possible resolution.
- If the parties are not able to resolve the dispute:
  - Each party shall document:
    - The issues in the dispute;
    - Their positions; and
    - Their efforts to resolve the dispute; and
  - The parties shall refer the dispute to the individual's support team for resolution.
  - The parties shall abide by the decision of the individual's support team.
  - If an individual's support team cannot resolve the matter, then the parties shall refer the matter to the individual's Service Coordinator for resolution of the dispute.
  - The Service Coordinator shall give the parties notice of the Service Coordinator's decision pursuant to IC 4-21.5.
  - Any part adversely affected or aggrieved by the Service Coordinator's decision may request administrative review of the

Service Coordinator's decision within fifteen (15) days after the party receives written notice of the Service Coordinator's decision.

- Administrative review shall be conducted pursuant to IAC 4-21.5

8.2 Plan of Care Cost Comparison Budget Updates and Revisions

Whenever the individual needs a change in the amount or type of services, the Targeted Case Manager, the individual and guardian, and, as appropriate, other members of the individual's support team will cooperatively revise the POC/CCB and Service Planner .

The Targeted Case Manager is responsible for developing the updated POC/CCB Service Planner following the same process indicated in the "Initial POC and CCB" section.

For all individuals whose CCBs are over $300 per day, the Targeted Case Manager must complete the "high cost comments" section of the POC/CCB that provides detailed and explicit explanations of at least the following issues:

a) The need for 24-hour staff supervision of the individual;
b) Identify what is needed by the individual to be healthy and safe in the community. (Strive to separate what is necessary to be healthy and safe from what is desired by the individual, family, advocates, etc.);
c) Describe how the individual's needs drive the Service Planner and budget;
d) Identify from where is the individual being deinstitutionalized (or diverted);
e) Describe the reason for 1:1 staffing or other high levels of staff supervision;
f) Explain why the individual does not have housemate(s) and plans for the individual to have a housemate; and
g) List the specific steps being taken, including time frames, to reduce the individual's behavioral, medical or other issues that may be causing the need for high levels of services and funding.

When an individual's health and safety are in jeopardy, the Targeted Case Manager and service providers must implement the POC/CCB and Service Planner immediately to protect the individual from harm to him/herself or others. The Targeted Case Manager must electronically transmit the POC/CCB and Service Planner to the Waiver Specialist within 3 calendar days.

Except when an individual's health or safety is in jeopardy, the Targeted Case Manager is responsible for entering the updated POC/CCB and Service Planner in the INsite database and electronically transmitting it to the Waiver Specialist at least 14 calendar days prior to its proposed effective date. The updated POC/ CCB is to reflect the updated services as well as all other Waiver services and their date ranges over the period covered by the annual POC/ CCB.

Within 5 calendar days of receiving them electronically from the Targeted Case Manager, the Waiver Specialist is to review the POC/CCB and Service Planner and must confirm that:

a) The individual is a current Medicaid recipient and meets the category of Aged, Blind, Disabled, Low Income Families, or Disabled Workers;
b) The individual has a current ICF/MR level of care approval for the waiver and a diagnosis of Autism;
c) The individual continues to have an available waiver slot;
d) The individual's identified needs will be met and health and safety will be assured;
e) The costs are consistent with the identified needs of the individual and the services to be provided;
f) That if the total cost of Medicaid waiver and regular Medicaid State Plan services for the individual exceeds the total costs of serving an individual with similar needs in an ICF/MR facility, the programmatic cost-effectiveness will be maintained;
g) BDDS funds to supplement the POC/CCB are available if required;
h) The individual or guardian has signed, indicating acceptance of the POC/CCB; signed that he/she has been offered choice of certified waiver service providers; and signed that he/she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Targeted Case Manager and BDDS District office to assist in reviewing the packet.

If the Waiver Specialist denies the POC/CCB, a denial letter must be transmitted to the Targeted Case Manager and BDDS. Within 5 calendar days of receipt of the denial, the Targeted Case Manager must complete and provide a copy of the Notice of Action *(HCBS Form 5)*, the denial letter, the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to deny to the individual or guardian. Other service options are to be discussed with the individual and guardian.

If the Waiver Specialist approves the POC/CCB, the approval letter is to be electronically transmitted to the Targeted Case Manager and BDDS. Within 5 calendar days of receipt of the approval letter, the Targeted Case Manager is to:

a) Print the Notice of Action *(HCBS Form 5)* from INsite, sign it; *and*
b) Provide copies of the Notice of Action, and Addendum containing information from the POC/CCB and Service Planner to the individual/guardian and to all the waiver service providers.

8.3 Annual Level of Care Determination

All individuals receiving waiver services must be re-determined to meet ICF/MR level of care criteria on an annual basis.

The level of care redetermination is to be made during the same month of the year in which the initial level of care determination was made. If the individual's condition changes significantly, level of care may be re-determined prior to the annual due date.

Annual level of care determinations are made by the Targeted Case Manager, or a QMRP if the Targeted Case Manager is not a QMRP, except:

- An OMPP QMRP must make the re-determination for children who have not reached their 6th birthday.

When OMPP must make the level of care redetermination:

- The Targeted Case Manager is to send the packet directly to OMPP;
- OMPP may request additional information from the Targeted Case Manager, BDDS, the individual, family, or providers to verify the accuracy of the DDP or developmental assessment;
- Within five days of receiving the completed level of care packet, OMPP will enter the level of care determination on the Transmittal (Form 7) and on the Form 450B and mail them directly to the Targeted Case Manager who submitted the packet;
- If level of care is denied, OMPP will also mail a letter to the Targeted Case Manager enumerating the specific reasons for denial.

If the determination by OMPP or the Targeted Case Manager is that the individual no longer meets ICF/MR level of care and therefore is ineligible for the Autism Waiver, the Targeted Case Manager must immediately complete a Notice of Action (*HCBS Form 5)* in the INsite database with the following statement:

> "As required under 42 CFR 441.301(b)(1)(iii)(C) and the approved Autism Waiver, you do not require the Level of Care provided in an ICF/MR in the absence of the waiver and community-based services."

The Notice of Action must be completed, signed and sent to the individual/guardian along with the Appeal Rights as an HCBS Waiver Services Recipient and a copy of the level of care denial determination. It is imperative that these actions are taken immediately to preserve the individual's appeal rights.

If level of care is denied, the individual must terminate Waiver services within 13 calendar days of the individual/guardian's receipt of the Notice of Action form notifying him/her of the denial unless the individual/guardian files an appeal. The individual may continue to receive Waiver services pending receipt of a decision in the appeal.

The level of care determination (and, if the level of care is denied, a Data Entry Worksheet *(HCBS DE T/D)* are to be entered into the INsite database and transmitted to the DDARS database.

If the level of care is denied and the individual/guardian chooses not to appeal the determination, the Targeted Case Manager must assist the individual/guardian in exploring alternative services and options to meet the needs of the individual. The individual continues to be entitled to Targeted Case Management services if he/she continues to meet the Medicaid and developmental disability eligibility criteria.

8.4 Annual Plan of Care and Cost Comparison Budget Development, Approval and Implementation

All individuals receiving Waiver services must have new POC/CCBs and Service Planners approved on an annual basis. Annual POC/CCBs are to start the date following the expiration of the Initial POC/CCB and cover a 12-month period.

The Targeted Case Manager must submit the Request for Information *(HCBS Form 6)* to the local DFC office to obtain Medicaid eligibility information including "spend down" or "liability". The DFC office is to complete the request within 7 calendar days of receipt and return it to the Targeted Case Manager.

The Targeted Case Manager is responsible for facilitating an update to the Person Centered Plan/Individualized Support Plan process with the

individual, guardian and additional participants the individual may request. The individual may choose another person to facilitate the Person Centered Plan/Individualized Support Plan process if that individual meets the qualifications to do so (See Section 5.).

The Targeted Case Manager is responsible for developing the "annual" POC/CCB and Service Planner in cooperation with the individual and guardian and, as appropriate, other members of the individual's support team.

Annual POC/CCBs and Service Planners are to follow the same criteria for submission, approval and implementation as described in the "POC/CCB Updates and Revisions" section. They are to be electronically transmitted to the Waiver Specialist at least 14 calendar days prior to the annual due date.

8.5 Authorization of Environmental Modifications and Specialized Medical Equipment and Supplies

Refer to Section 7.10 for steps to follow when including these items in updated and annual POC/CCBs.

8.6 Termination of Waiver Services

An individual's waiver services will be terminated when the individual:

1. Voluntarily withdrawals;
2. Chooses institutional placement/entering Medicaid-funded long-term care facility;
3. Dies;
4. Needs services so substantial that the total cost of Medicaid services for the individual would jeopardize the Waiver program's cost effectiveness;
5. No longer meets ICF/MR level of care criteria;
6. Is no longer eligible for Medicaid services;
7. No longer requires Home and Community-Based Services; or
8. Is no longer developmentally disabled.

When an individual terminates Waiver services, the Targeted Case Manager must complete a "termination" Data Entry Worksheet *(State form DE T/D*), enter the information in the INsite database, and electronically transmit the information to the DDARS database. The Data Entry Worksheet is also automatically transmitted to OMPP to enter the Waiver termination information in the Indiana AIM database.

The Targeted Case Manager must complete a Notice of Action *(HCBS Form 5)* and, within 5 calendar days of the termination, provide the individual or guardian with a copy of the form, the *Appeal Rights as an HCBS Waiver Services Recipient* instructions, and an explanation of the termination. As appropriate, other service options are to be discussed with the individual and guardian.

8.7 Waiver Slot Retention After Termination and Re-Entry

If an individual who has been terminated from the Waiver wishes to return to the program, he or she may do so within the same Waiver year of his or her termination, if otherwise eligible. The individual shall return to the Waiver without going on a waiting list. "Within the same Waiver year" is considered to be from January 1 through December 31 of the same year.

An individual who has been terminated from the Waiver program within 30 calendar days may resume the Waiver with the same level of care approval date and POC/CCB and Service Planner if the individual's condition has not significantly changed and the POC/CCB and Service Planner continue to meet his or her needs.

- The Targeted Case Manager must certify that the individual continues to meet ICF/MR level of care criteria.
- The Targeted Case Manager must complete a "Resumption" Data Entry Worksheet, enter it in the INsite database, and submit it electronically to the DDARS database. The information will be automatically transmitted to the OMPP to enter into the Indiana AIM database.

If an individual who has been terminated from the Waiver program longer than 30 calendar days wishes to return to the program and is otherwise eligible, the Targeted Case Manager is responsible for developing the level of care packet and POC/CCB and Service Planner following the same processes described in the "Annual Level of Care Determination" and the "Initial POC/CCB" sections.

- The Targeted Case Manager is to indicate a "Re-Entry" POC/CCB and Service Planner when electronically transmitting them to the waiver specialist.
- When the individual "Re-Enters" Waiver services, the Targeted Case Manager must enter a Confirmation of Waiver Start form in the INsite database and electronically transmits it to the DDARS database. The information will be automatically transmitted to OMPP to enter in the Indiana AIM database.

- When the Confirmation of Waiver Start form is received electronically by DDARS, an approval letter will be automatically transmitted back to the Targeted Case Manager.
- Within 3 days of receiving the Re-Entry POC/CCB approval letter, the Targeted Case Manager must print a Notice of Action (*HCBS Form 5*) and sign it. The Targeted Case Manager must provide copies of the Notice of Action form and Addendum (containing information from the POC/CCB and Service Planner) to the individual/guardian and to all of the individual's waiver service providers.

When an individual "re-enters" Waiver services:

- If within 30 days of terminating Waiver services, the annual level of care and POC/CCB dates remain the same dates as they were prior to the termination of Waiver services,
- If more than 30 days since terminating Waiver services, the new level of care and POC/CCB dates are used for determining when future annual level of care determinations and POC/CCBs are due.

8.8 Transfer of Client Information From One Targeted Case Manager to Another

Individuals or guardians may choose a new Targeted Case Manager at any time. It is the responsibility of both Targeted Case Managers to work cooperatively with the individual to determine a transition date and assure a smooth transition of case management and Waiver services.

Pursuant to 460 IAC 6-9-6, and as amended,

a) The new Targeted Case Manager shall:
    1) Discuss with the individual/guardian the new Targeted Case Manager's need to obtain a copy of the previous Targeted Case Manager's records (including records entered in the INsite database) and files concerning the individual;
    2) Provide the individual with a written form used to authorize the previous Targeted Case Manager records and files to the new Targeted Case Manager; and
    3) Request the individual/guardian sign the release form.
b) Upon receipt of a written release signed by the individual/guardian, a Targeted Case Manager shall forward a copy of all of the individual's records (including transferring records entered in the INsite database) and files to the new Targeted Case Manager no later than 7 days after receipt of the written release signed by the individual/guardian.

8.9 Case Transfers - From One Waiver To Another

When an individual transfers from one waiver to another waiver, the individual must terminate the first waiver and be opened on the new waiver.

The Targeted Case Manager shall not terminate the individual from the first waiver until the level of care, POC/CCB, and new waiver start date have been approved for the new waiver.

Within five calendar days of terminating the first waiver, the Targeted Case Manager must complete a "termination" Date Entry Worksheet *(form DE D/T)* in INsite and electronically transmit it to the DDARS database The information will be automatically transmitted to the OMPP for entry into the Indiana AIM database.

If an individual no longer meets level of care criteria for the first waiver but has been determined to meet level of care criteria for a second waiver, he or she may transfer to the new waiver if a slot is available. If no slot is available, the individual's application date for the first waiver is to be used in determining his or her place on the waiting list for the second waiver.

9. Bureau of Quality Improvement Services (BQIS)

9.1 Organization of BQIS

The Bureau of Quality Improvement Services (BQIS) under the Division of Disability, Aging, and Rehabilitative Services (DDARS) is responsible for monitoring supported living services, including waiver services. BQIS consists of 3 major units:

9.1.1 The Provider & Case Management Standards Compliance Unit completes provider and case management surveys, quality of life surveys, and transition monitoring for people moving out of the State Developmental Centers. This unit also coordinates the corrective action needed when concerns are found during the surveys, and determines when concerns are satisfactorily resolved. Consumers, families and/or guardians are notified of the results of the surveys, including any corrective action that is required.

9.1.2 The Incident Reporting & Complaints Unit manages the incident reporting process, tracks and investigates complaints, and completes trend analyses and reports. Included in this unit is the Developmental Disabilities Waiver Ombudsman, who handles calls from people with developmental disabilities and families with concerns and problems about their waiver services.

9.1.3 The Quality Assurance/Quality Improvement Systems Implementation Unit assists the Director in establishing and strengthening quality assurance and quality improvement processes throughout the state.

9.1.3.1 Provider Surveys

BQIS field staff throughout the state are responsible for completing annual surveys on all providers and case managers providing services to individuals with developmental disabilities funded by the DD Waiver, the Autism Waiver, and the Bureau of Developmental Disabilities Services. Surveys are measured against 460 IAC 6 which includes qualifications for approved providers of supported living services and supports; the

process by which the BDDS approves providers; the bureau's process for monitoring and ensuring compliance with provider standards and requirements; the rights of individuals receiving services; protection of individuals receiving services; and standards and requirements for approved providers of supported living services and supports. The focus of the surveys is to assess the services provided to individuals based on each individual's Support Plan.

The information obtained during the survey is shared with the service providers, the case manger and the BDDS District Office. The information from the surveys is used to assess the quality of life of individuals receiving services, to identify deficiencies in the service delivery system, and to provide for continuous quality improvement.

If deficiencies are noted during the survey, the appropriate entity will be asked to correct the situation. The BQIS field staff also make unannounced visits to individuals when complaints have been lodged or when situations described in incident reports need investigation.

9.1.3.2 Core Indicators Project Surveys

In January 1997, the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI) launched the Core Indicators Project (CIP). The project's aim is to develop nationally recognized performance and outcome indicators that will enable developmental disabilities policymakers to benchmark the performance of their state against the performance of other states. CIP performance indicators also enable each state developmental disabilities agency to track system performance and outcomes from year to year on a consistent basis.

The CIP is a collaboration among participating NASDDDS member state agencies and HSRI, the objective of which is to develop a systematic approach to performance and outcome

measurement. The adoption of performance indicators as a quality assurance technique is both a consequence of the change in expectations as well as a method for maintaining a focus on person-centered outcomes.

Through the project, participating states pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies, and share results. Indiana joined the CIP in Phase IV, which began June 2001.

There are 3 types of standardized survey tools utilized in the CIP:

- A consumer interview/survey tool;
- A family survey tool; and
- A provider survey tool.

Each is used to gather information for specific project outcomes and performance indicators. The BQIS field staff conduct the consumer survey portion of the project with a random sample drawn from individuals who are receiving services from the Autism Waiver. The family survey will be mailed to a random sample of families with a family member with a developmental disability regardless of where the family member resides. The provider survey will be mailed to all core service providers of the Autism Waiver. The response rate to these survey is critical to the overall success of this project.

The survey report for providers, systems and consumers published in 2002 can be accessed via http://www.in.gov/fssa/servicedisabl/ddars/cip.html.

9.2 Quality Improvement Committee Structure

A key function of BQIS is the development and management of a QI committee structure that has been established to address a wide range of quality improvement areas. These committees are:

a) Mortality Review Committee;

b) Risk Management Committee;
c) Consumer/Community Advisory Council; and
d) Standards Committee.

These committees review and analyze pertinent data and information and develop recommendations that are designed to improve the quality of services provided. Recommendations from each committee are forwarded to the Quality Improvement Executive Council, QIEC, which is DDARS strategic planning and policy development body. BQIS monitors the implementation and impact of recommendations agreed upon by the QIEC.

9.2.1 Mortality Review Committee (MRC)

The MRC was established effective February 2, 2000, to review all deaths that occur within the service delivery system for individuals with developmental disabilities. The MRC uses information gathered during the review to determine trends, direct training needs, make recommendations to address concerns, and provide an effective feedback mechanism to service providers and other appropriate stakeholders.

When a death occurs, a procedure is initiated that requires providers to report the death to DDARS by telephone (317) 232-1046, within 24 hours or by the close of the next business day; and to report the death by filing an incident report according to BDDS Incident Reporting Policy. The case is referred to the MRC. The provider must give DDARS additional written information about the circumstances of the death, the health status of the individual before and at the time of death, and the individual's activities and staff interaction in the 7 days prior to the death. If the death occurred in a hospital setting, the individual's activities and staff interactions in the 7 days that services were provided to the individual prior to the hospitalization are necessary. This information is sent to the MRC for its review, along with the death certificate, autopsy report, coroner report, hospital and physician records, and when appropriate, the individual's support plan, behavior plan, and the provider's internal policies and procedures.

The policy and related information can be found at http://www.in.gov/fssa/servicedisabl/

9.3 Reporting of Medicaid Fraud

Examples of Medicaid program fraud are as follows:

- A provider bills for services other than those authorized by the Plan of Care or for services that the individual does not need;
- A provider bills Medicaid for services a the individual did not receive;
- An individual gives or lends his/her Medicaid card to another individual with the intent of that individual receiving Medicaid services;
- A provider bills for more or different services(s) than the individual actually received.

Information related to Medicaid fraud should be reported to:

EDS Surveillance and Utilization Review Unit
P.O. Box 68764
Indianapolis, Indiana 46268-0764
1-800-457-4515 or (317) 488-5045
and

Indiana Medicaid Fraud Control Unit
Office of the Attorney General
Room 219, State House
200 West Washington Street
Indianapolis, Indiana 46204-2794
1-800 382-1039 or (317) 232-6520

10. Appeal Process

10.1 Appeal Request

An appeal is a request for a hearing before an Administrative Law Judge with the Family and Social Services Administration, Hearings and Appeals Section. The purpose of an appeal is to determine whether a decision made by a Service Coordinator, a Targeted Case Manager, or the Office of Medicaid Policy and Planning Level of Care Unit, affecting the recipient/consumer, is correct. An appeal request must be in writing and forwarded to the hearing authority.

10.1.1 Definitions

- A Service Coordinator is an employee of the Bureau of Developmental Disabilities Services (BDDS) with the responsibility to perform various job functions related to the planning, coordination, and oversight of services for persons with a developmental disability.

- A Targeted Case Manager is a certified and approved individual chosen by an individual with developmental disabilities and/or the individual's family to coordinate the individual's services.

- Office of Medicaid Policy and Planning Level of Care Unit is an entity within the Family and Social Services Administration with the responsibility of determining level of care for non-routine Autism Waiver cases.

10.1.2 Appeal Regulations

Decisions made by a Service Coordinator, a Targeted Case Manager, or the Office of Medicaid Policy and Planning Level of Care Unit can be appealed. For actions regarding Medicaid services the appeal is conducted under 405 IAC 1.1-1 et seq. For actions regarding state funded Developmental Disabilities Services the appeal is conducted under I.C. 4-21.5, the Indiana Administrative Orders and Procedures Act (AOPA).

10.2 Appeal Track for Medicaid Actions

The hearing authority for Medicaid actions under the Autism Waiver is 405 IAC 1.1-1 et seq.

10.2.1 Written Request for Appeal

An individual (or representative) must make an appeal request in writing. The written appeal request must be submitted to the Family and Social Services Administration, Hearings and Appeals Section, 402 W. Washington Street, Room 392, Mail Stop 04, Indianapolis, Indiana 46204 . This appeal request will also be faxed to the Hearings and Appeals Section at (317) 232-4412.

10.2.2 Assistance in Exercising the Right to Appeal

Any applicant for services or any individual receiving services via the Autism Waiver who is dissatisfied with an action may request a fair hearing. Any time an individual expresses a disagreement with any action taken, he/she must be verbally reminded of the right to request a fair hearing. Assistance is to be provided to the individual who is having difficulty in preparing the written request for an appeal.

The individual is to be informed that he/she may represent himself/herself at the hearing or be represented by an attorney, a relative, a friend, or any other spokesman of his/her choice. Information and referral services should also be provided to help the dissatisfied individual make use of any free legal services that are available in the community.

10.2.3 Appealable Actions

Under 405 IAC 1.1-1 et seq. appealable actions are issues relating to the waiting list; no waiver slots being available; initial, annual, and periodic level of care determinations; both initial and annual plans of care including service plans and cost comparison budgets; termination of waiver services; re-entry into the waiver after termination; and waiver transfers.

10.2.4 Group Appeals

Family and Social Services Administration, Hearings and Appeals Section, may respond to a series of requests for hearings by

providing group hearings or similar questions or changes in federal or state law or regulation. Similarly, a group of individuals who wish to appeal some aspect of policy may request to be heard as a group. If there is disagreement as to whether the issue is one of federal or state law or regulation or the facts of an appellant's personal situation, Hearings and Appeals will make the decision as to whether the appeal may be included in a group hearing.

The Administrative Law Judge may limit the discussion in a group hearing to the sole issue under appeal. When an appellant's request for a hearing involves additional issues to the one serving as the basis for the group hearing, the appeal will be handled individually. An appellant scheduled for a group hearing may choose to withdraw and be granted an individual hearing even if the grievance is limited to the sole issue involved in the group hearing.

Policies governing the conduct of individual hearings are pertinent to group hearings. Each appellant (or representative) will be given full opportunity to present the case (or have the case presented by a representative).

10.2.5 Time Limits for Requesting Appeals

Appeals are to be filed not later than thirty (30) days following the effective date of the action, or thirty (30) days following the date the notice of the decision was mailed (whichever is later).

10.2.6 Continuation of Benefits

The appellant is entitled to continue benefits after requesting a hearing only if the request is received prior to the effective date of the proposed action.

Once continued benefits are allowed, benefits are not to be reduced or terminated prior to receipt of the official hearing decision. If a new action is proposed for a different time period and the recipient does not request an appeal, the new action can take place even if the pervious appeal is still continuing.

10.2.7 The Hearing Notice

The Family and Social Services Administration, Hearings and Appeals Section, sends a notice acknowledging the appeal. The

notice is sent to all parties, which includes the individual (the representative), the Service Coordinator and/or the Targeted Case Manager. The Office of Medicaid Policy and Planning Level of Care Unit would also be included in receiving a notice if they were involved in making the decision. The notice of the hearing will:

- include a statement of the date, time, place, and nature of the hearing which is always conducted in the appellant's county of residency;

- advises the appellant of the name, address, and phone number of the person to notify in the event it is not possible for him to attend;

- specifies that the hearing request will be dismissed if the appellant fails to appear for the hearing without good cause;

- specifies that the appellant may request a continuance of the hearing if good cause is shown;

- includes the appellant's rights, information, and procedures to provide the appellant, or representative with an understanding of the hearing process; and

- explains that the appellant may examine the case record prior to the hearing.

The Notice of Scheduled Hearing is sent out so that it reaches the appellant at least 10 days prior to the hearing.

10.2.8 Request for Continuance from the Appellant

A written request for a continuance is to be directed to the Hearings and Appeals Section. Good cause must exist for a continuance to be granted. Good cause is defined as a valid reason for the appellant's inability to be present at the scheduled hearing such as inability to attend the hearing because of a serious physical or mental condition, incapacitating injury, death in the family, severe weather conditions making it impossible to travel to the hearing, unavailability of a witness and the evidence cannot be obtained otherwise, or other reasons similar to those listed in this section. If good cause exists and a continuance is granted, the hearing is rescheduled.

10.2.9 Review of Action

When an appeal request is received, the Service Coordinator and/or the Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit should review the proposed action to determine whether the proposed action is appropriate.

The Service Coordinator and/or the Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit (or representative) must offer the individual (or representative) the possibility of an informal conference and an opportunity to review the evidence prior to the hearing. Individuals should be advised that an informal conference prior to the hearing is optional and in no way delays or replaces the administrative hearing. The conference may lead to an informal resolution of the dispute. An administrative hearing must still be held unless the individual (or representative) in writing withdraws the request for a hearing.

10.2.10 Disposal of Appeal Without a Fair Hearing

An appeal request may be disposed of without holding a fair hearing in the following situations:

- If, after review of the appellant's situation, the Service Coordinator and/or the Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit realizes that the proposed action or action taken is incorrect, then adjusting action may be taken. The appellant and the Hearings and Appeals Section are to be promptly notified in writing that the incorrect action is being withdrawn or rescinded.

- If the appellant wishes to withdraw the appeal, he/she is to be assisted by the Service Coordination and/or the Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit in promptly notifying the Hearings and Appeals Section in writing of the decision. No pressure is to be exerted on the appellant to withdraw the appeal. The withdrawal will be acknowledged in writing. The appeal is then dismissed.

- When the withdrawal of an appeal request is not submitted in writing, the Hearings and Appeals Section will notify the parties that the appeal will be dismissed unless notification is received promptly that the appellant did not, in fact, withdraw the appeal request.

- An appeal is abandoned when the appellant (or representative) without good cause, does not appear at a scheduled hearing. The appeal will be dismissed and the parties so notified.

10.2.11 The Fair Hearing

An administrative hearing is a review of an action(s) taken by a Service Coordinator and/or a Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit regarding issues relating to the Autism Waiver. An Administrative Law Judge, who is an employee of the Family and Social Services Administration, Hearings and Appeals Section, is designated to hold the hearing and to issue findings of fact, conclusions of law, and a decision related to the appeal request.

A hearing allows the dissatisfied appellant an opportunity to present his/her grievance and to describe the circumstance and needs in his/her own words. The individual may be represented by an attorney or another individual of his choice. The Service Coordinator and/or the Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit (or representative) will attend the hearing and present evidence supporting the action under appeal.

10.2.12 Preparation for Hearing by Appellant

As the appellant prepares for the hearing, the appellant (or representative) is to be given an opportunity to:

- Discuss the issue being appealed with the Service Coordinator and/or Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit (or representative).

- Examine the entire case file and all documents and records that will be used by the Service Coordinator and/or Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit at the hearing.

- Obtain free of charge copies of all exhibits that will be used as evidence by the Service Coordinator and/or Case Manager or the Office of Medicaid Policy and Planing Level of Care Unit at the hearing.

- The appellant is to be advised of any legal services available that can provide representation at the hearing.

10.2.13 Preparation for Hearing by the Service Coordinator and/or the Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit

The correct application of federal or state law or regulation to the appellant's situation should be reviewed by the Service Coordinator and/or the Targeted Case Manager of the Office of Medicaid Policy and Planning Level of Care Unit prior to the hearing. Thorough support of the action proposed or taken must be provided at the hearing.

The person testifying should be the person with the most direct contact with the action being proposed or taken. In the absence of the person with the most knowledge of the hearing situation, a person familiar with the action and the case record should substitute.

To prepare for the hearing, the Service Coordinator and/or the Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit is to:

- Review all factors and issues that led to the action being appealed;

- Discuss the issue being appealed with the appellant (or representative) if at all possible, and definitely if a discussion is requested by the appellant. If requested, allow the appellant (or representative) to examine the entire case record;

- Identify and label all documents that are pertinent to the issue under appeal. The exhibits should be labeled in the lower right hand corner with the State's Exhibit being Exhibit A. If more than one page is in an exhibit, the pages are labeled (for the first page) State's Exhibit A, page 1 of 2; and (for page 2) State's Exhibit A, page 2 or 2. The next numbers continue for each page in the exhibit being presented. The subsequent exhibit would be labeled Exhibit B and the pages according to the number of pages. Example [If three pages are in an exhibit, the third page would be labeled]:

  State's Exhibit A

- Make one copy of labeled exhibits for the Administrative Law Judge and one copy for the appellant (unless already given to the appellant). A duplicate copy of the notice sent to the appellant advising of the proposed action should be included as part of the documentation;

- Prepare a written outline that can be used as a tool in presenting the testimony at the hearing. Bear in mind when preparing the outline that the Administrative Law Judge knows nothing about the situation. The outline should focus on:

    - identification of the staff representative by name and position;
    - the period of time the representative worked directly or indirectly with the appellant;
    - one sentence explanation of the issue under appeal;
    - the important information concerning how it was determined that the action proposed or taken was appropriate; and
    - federal and state laws and regulations that were the basis for the action.

- Include the labeled exhibits at the appropriate point in the presentation outline.

10.2.14 Conduct of the Hearing

The Administrative Law Judge conducts the hearing. Both the appellant and the Service Coordinator and/or the Targeted Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit have the opportunity to:

- Present the case or have it presented by legal counsel or another person;

- Present testimony of witnesses;

- Introduce relevant documentary evidence;

- Establish all pertinent facts and circumstances;

- Present any arguments without interference;

- Question or refute any testimony or evidence presented by the other party, including the opportunity to confront and cross-examine any adverse witnesses; and

- Examine the appellant's entire case record and all documents and records used by the Service Coordinator and/or the Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit at the hearing.

  The parties are advised at the close of the hearing that they will be informed in writing of the Administrative Law Judge's decision.

10.2.15 Responsibility of the Service Coordinator and/or the Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit at the Hearing

At the hearing, the Service Coordinator and/or the Case Manager or the Office of Medicaid Policy and Planning Level of Care Unit (or representative) is to:

- Present the testimony according to the outline prepared prior to the hearing;

  - Limit remarks to facts (not speculation or guessing);

  - Avoid the use of jargon;

  - Offer labeled exhibits into evidence at appropriate points in the testimony and explain what they are and how they relate to the issue;

- Offer the labeled exhibits to the appellant (or representative) for examination and objections (if any); and

  - Come to the hearing prepared to question the appellant about any statements that need further explanation.

10.2.16 Continuance of Hearing

If the Administrative Law Judge determines that further evidence is needed to reach a decision, the decision is delayed until such

further evidence is obtained. The hearing may also be reconvened, if necessary, to obtain additional testimony. The parties will be notified of this and of the time and method for obtaining this evidence. Any evidence submitted must be copied and given to the opposite party, who then has the opportunity for rebuttal.

10.2.17 The Hearing Record

The hearing record is an official report containing the transcript or recording of the testimony of the hearing, together with all papers and requests filed in the proceeding, and the decision of the Administrative Law Judge.

10.2.18 The Fair Hearing Decision

A written copy of the Administrative Law Judge's hearing decision is sent to all parties. The decision includes:

- The findings of fact and conclusions of law regarding the issue under appeal; and
- Supporting laws and regulations.

In all cases the decision of the Administrative Law Judge is based solely on the evidence introduced at the hearing and the appropriate federal and state laws and regulations. The Administrative Law Judge signs the decision which also contains the findings of fact and the conclusions of law. The decision is to be explained to the appellant upon request.

10.2.19 Actions of the Administrative Law Judge's Decision

The decision of the Administrative Law Judge shall be binding upon the Division of Disability, Aging, and Rehabilitative Services or the Office of Medicaid Policy and Planning and is to be enacted even if one of the parties requests an Agency Review. Such decisions do not preclude modifying changed conditions subsequent to the original appeal request as long as the change does not relate to the issue under appeal.

10.2.20 Agency Review

Any party may request an Agency Review if dissatisfied with the decision made by the Administrative Law Judge. The Agency Review request must be made in writing to the Family and Social Services Administration, Hearings and Appeals Section, within 10 days following receipt of the hearing decision.

Once an Agency Review is requested, the Hearings and Appeals Section will write to all parties to acknowledge receipt of the request and to provide information concerning the review.

No new evidence will be considered during the Agency Review; however, any party may submit a written Memorandum Of Law , citing evidence in the record, for consideration.

The agency review shall be completed by the Secretary of the Family and Social Services Administration or the Secretary's designee. The decision made at Agency Review will be sent to all appropriate parties.

10.2.21 Judicial Review

The appellant, if not satisfied with the final action, may file a petition for judicial review in accordance with IC 4-21.5-5.

10.2.22 Lawsuits

If a lawsuit is filed, the DDARS District Manager should direct all inquiries to the FSSA Office of General Counsel.

!0.3 Appeal Track For State Funded Developmental Disabilities Services Actions

The hearing authority for state funded developmental disability services actions is governed by IC 4-21.5, the Indiana Administrative Orders and Procedures Act (AOPA).

An individual must make an appeal request in writing by sending a Request for Administrative Review form to the Director of the Division of Disability, Aging, and Rehabilitative Services, 402 W. Washington Street, Room 451, Mail Stop 26, Indianapolis, Indiana 46404. In the absence of the form, any written request for an appeal shall be accepted.

10.3.1 Assistance in Exercising the Right to Appeal

Any applicant for services or any individual receiving services via state funds with the Bureau of Developmental Disabilities Services who is dissatisfied with an action may request a fair hearing. Any time an individual expresses a disagreement with any action taken, he/she must be verbally reminded of the right to request a fair hearing. Assistance is to be provided to the individual who is having difficulty in preparing the written request for an appeal.

The individual is to be informed that he/she may represent himself/herself at the hearing or be represented by an attorney, a relative, a friend, or any other spokesman of his/her choice. Information and referral services should also be provided to help the dissatisfied individual make use of any free legal services that are available in the community.

10.3.2 Appealable Actions

Under IC 4-21.5-2 appealable actions are issues relating to developmental disability eligibility; an individual community living budget (ICLB) pertaining to residential living allowance (RLA) and start up funds only; and Title XX sheltered work.

10.3.3 Time Limits for Requesting Appeals

Appeals must be filed within 15 days of the date of the action or issue being appealed.

An Administrative Law Judge will be assigned to hear the appeal by the Program Director acting as proxy for the Director of the Division of Disability, Aging, and Rehabilitative Services. The Administrative Law Judge shall schedule the hearing at the convenience of all parties.

Each appeal shall be assigned a sequential case number by district and by quarter and the fiscal year (i.e. D2-01-01) and logged into the appeals database.

10.3.4 The Hearing Notice

The Administrative Law Judge for the hearing shall set the time and place of the hearing and give reasonable written notice to all

parties and to all persons who have filed written petitions to intervene in the matter. Unless a shorter notice is required to comply with any law or is stipulated by all parties and persons filing written requests for intervention, an agency shall be given at least 5 days notice of the hearing.

The notice scheduling the hearing must include:

- a copy of any prehearing order rendered in the matter;
- the names and mailing addresses of all parties and other persons to whom notice is being given by the Administrative Law Judge;
- the name, official title, and mailing address of any counsel or employee who has been designated to appear for the agency and a telephone number through which the counsel or employee can be reached;
- the official file or other reference number, the name of the proceeding, and a general description of the subject matter;
- a statement of the time, place, and nature of the hearing;
- a statement of the legal authority and jurisdiction under which the hearing is to be held;
- The name, official title, and mailing address of the Administrative Law Judge and a telephone number through which information concerning hearing schedules and procedures may be obtained; and
- A statement of the issues involved and, to the extent known by the Administrative Law Judge, of the matters asserted by the parties.

10.3.5 Pleadings, Motions, Objections, and Offers of Settlement

The Administrative Law Judge, at appropriate stages of a proceeding, shall give all parties full opportunity to file pleadings, motions, and objections and submit offers of settlement.

- The Administrative Law Judge, at appropriate stages of a proceeding, may give all parties full opportunity to file briefs, propose findings of fact, and propose orders.

- A party shall serve copies of any filed item on all parties.

    - The Administrative Law Judge shall serve copies of all notices, orders, and other papers generated by the Administrative Law Judge to all parties.

10.3.6 Review of Action

When an appeal request is received, the Service Coordinator should review the proposed action to determine whether the proposed action is appropriate.

The Service Coordinator must offer the individual (or representative) the possibility of an informal reconsideration conference. Individuals should be advised that an informal reconsideration conference is optional and in no way delays or replaces the administrative hearing. The conference may lead to an informal resolution of the dispute. An administrative hearing must still be held unless the individual (or representative) in writing withdraws the request for a hearing.

10.3.7 The Hearing

An administrative hearing is a review of an action(s) taken by a Service Coordinator regarding issues relating to state funded Developmental Disabilities Services benefits. An Administrative Law Judge, is designated to hold the hearing and to issue findings of fact, conclusions of law, and a decision related to the appeal request.

A hearing allows the dissatisfied appellant an opportunity to present his/her grievance and to describe his/her circumstance and needs in his/her own words. An attorney, or another individual of their choice may represent the individual. The Service Coordinator will attend the hearing and present evidence supporting the action under appeal.

10.3.8 Preparation for Hearing by Appellant

As the appellant prepares for the hearing, he /she (or representative) is to be given an opportunity to:

- Discuss the issue being appealed with the Service Coordinator.

- Examine the entire case record and all documents and records that will be used by the Service Coordinator at the hearing.

- Obtain free of charge copies of all exhibits that will be used as evidence by the Service Coordinator at the hearing.

- The appellant is to be advised of any legal services available that can provide representation at the hearing.

10.3.9 Preparation by the Service Coordinator for a Hearing

The Service Coordinator prior to the hearing shall review the correct application of state law or regulation to the appellant's situation. Thorough support of the action proposed or taken must be provided at the hearing.

The Service Coordinator should be the person providing testimony at the hearing. In the absence of the Service Coordinator being present, a person familiar with the action and the case record should substitute.

To prepare for the hearing, the Service Coordinator is to:

- Review all factors and issues that led to the action being appealed;

- Discuss the issue being appealed with the appellant (or representative) if at all possible, and definitely if a discussion is requested by the appellant. If requested, allow the appellant (or representative) to examine the entire case record;

- Identify and label all documents that are pertinent to the issue under appeal and label them. The exhibits should be labeled in the lower right hand corner with the Bureau of Developmental Disabilities Services being Exhibit A. If more than one page is in an exhibit the pages are labeled (for the first page) Bureau of Developmental Disabilities Services Exhibit A, page 1 of 2, and (for page 2), Bureau of Developmental Disabilities Services Exhibit A, page 2 or 2. The numbers continue for each page in the exhibit being presented. The subsequent exhibit would be labeled Exhibit B and the pages according to the number of pages. Example [If three pages are in an exhibit, the third page would be labeled]:

- Make one copy of the exhibits for the Administrative Law Judge and one copy for the appellant (unless already given to the appellant). A duplicate copy of the notice sent to the appellant advising of the proposed action should be included as part of the documentation;

- Prepare a written outline that can be used as a tool in presenting the testimony of the Service Coordinator at the hearing. Bear in mind when preparing the outline that the Administrative Law Judge knows nothing about the situation. The outline should focus on:

  - identification of the Service Coordinator by name and position;
  - the period of time the Service Coordinator worked directly or indirectly with the appellant;
  - one sentence explanation of the issue under appeal;
  - the important information concerning how the Service Coordinator determined that the action proposed or taken was appropriate; and
  - state laws and regulations that were the basis for the action.

- Evidence submitted for eligibility determination decisions shall include the following:

  - a copy of diagnostic information upon which eligibility determination has been based;
  - a copy of the eligibility statement;
  - a copy of the denial letter;
  - a copy of the policy and operational directive used to make the eligibility decision; and
  - any other pertinent information regarding the decision.

  Include the labeled exhibits at the appropriate point in the presentation outline.

10.3.10 Conduct of the Hearing

The Administrative Law Judge governs the conduct of any hearing. The Administrative Law Judge:

- shall regulate the course of the proceedings in conformity with any prehearing order and in an informal manner without recourse to the technical, common law rules of evidence applicable to civil actions in the courts.

    - To the extent necessary for full disclosure of all relevant facts and issues, shall afford to all parties the opportunity to respond, present evidence and argument, conduct cross-examination, and submit rebuttal evidence, except as restricted by limitations.

- May, after issuance of a prehearing order, impose conditions upon a party necessary to avoid unreasonably burdensome or repetitious presentations by the party.

The parties are advised at the close of the hearing that they will be informed in writing of the Administrative Law Judge's findings and decision on the appeal as soon as possible.

10.3.11 Service Coordinator's Responsibility at the Hearing

At the hearing the Service Coordinator is to:

- Present the testimony according to the outline prepared prior to the hearing;

    - Limit remarks to facts (not speculation or guessing);

    - Avoid the use of jargon;

    - Offer labeled exhibits into evidence at appropriate points in the testimony and explain how these exhibits relate to the issue;

    - Offer the labeled exhibits to the appellant (or representative) for examination and objections (if any); and

    - Come to the hearing prepared to question the appellant about any statements that need further explanation.

10.3.12 The Hearing Record

The hearing record is an official report containing the transcript or recording of the testimony of the hearing, together with all papers and requests filed in the proceeding, and the decision of the Administrative Law Judge.

10.3.13 The Hearing Order

The Administrative Law Judge shall make a non-final written Order based upon relevant Indiana Code and the evidence of record in the proceeding. The Administrative Law Judge shall issue an Order including, separately stated, the findings of fact for all aspects of the Order and the prescribed remedy. The Administrative Law Judge shall have copies of the Order delivered to each party and to the Director of the Division of Disability, Aging, and Rehabilitative Services. The findings of fact shall be accompanied by a concise statement of the underlying facts of the record to support the findings. The Order shall also include a statement regarding the process for further appeal of the Order and the time frame for seeking Administrative Review of the Order. The findings shall be sent to all parties and the Deputy Director of the Division of Disability, Aging, and Rehabilitative Services within 90 days of the conclusion of the hearing or after the submission of the proposed findings. The time period may be waived or extended with the written consent of all parties or for good cause shown.

10.3.14 Objection to Non-Final Order

If the appellant is dissatisfied with the non-final Order issued by the Administrative Law Judge, the appellant may appeal to the Director of the Division of Disability, Aging, and Rehabilitative Services in writing within 15 days of the non-final Order.

If the Bureau of Developmental Disabilities Services is dissatisfied with the non-final Order, an objection may be filed in writing to the Director of the Division of Disability, Aging, and Rehabilitative Services within 15 days of the non-final Order.

10.3.15 Responsibility of the Director of the Division of Disability, Aging, and Rehabilitative Services when Objections are Filed

If an Objection is filed, the Director of the Division of Disability, Aging, and Rehabilitative Services shall conduct proceedings to issue a final Order. In these proceedings the Director shall give each party an opportunity to present further arguments. The Director may:

- give each party the opportunity to provide oral arguments;
- have a transcript prepared of any portion of the record of a proceeding that the Director considers necessary;
- exercise the powers of an Administrative Law Judge; or
- allow non-parties to participate in a proceeding.

In reviewing a non-final Order, the Director of the Division of Disability, Aging, and Rehabilitative Services shall base the decision on the evidence in the record. The Director of the Division of Disability, Aging, and Rehabilitative Services shall issue an Order affirming, modifying, or dissolving the Administrative Law Judge's Order. The Director may remand the matter, with or without instructions, to the Administrative Law Judge for further proceedings.

10.3.16 Responsibility of the Director of the Division of Disability, Aging, and Rehabilitative Services when No Objections are Filed

If no Objection is filed, the Director of the Division of Disability, Aging, and Rehabilitative Services may serve written notice of intent to review any issue related to the non-final Order of the Administrative Law Judge. The notice shall be served on all parties and must identify the issues that the Director intends to review. In reviewing a non-final Order, the Director of the Division of Disability, Aging, and Rehabilitative Services shall base the decision on the evidence in the record.

10.3.17 Final Order

If no Objection or notice of intent to review is filed, the Director of the Division of Disability, Aging, and Rehabilitative Services will affirm the non-final Order of the Administrative Law Judge as the agency's final Order. A final Order shall be issued by the Director of the Division of Disability, Aging, and Rehabilitative Services within 60 days after the latter of:

- the date the Administrative Law Judge's Order was issued;
- the receipt of written comments; or
- the close of oral arguments.

The final Order shall identify any difference between the final Order and Order issued by the Administrative Law Judge which includes findings of fact or incorporates the findings of fact in the Administrative Law Judge's Order.

10.3.18 Judicial Review

If an individual is not satisfied with the Final Order issued by the Director of the Division of Disability, Aging, and Rehabilitative Services, the individual may file a petition for judicial review in accordance with IC 4-21.5-5.

10.3.19 Lawsuits

If a lawsuit is filed, the Bureau of Developmental Disabilities Services District Manager should direct all inquiries to the FSSA Office of General Counsel.

11. RELATED DOCUMENTS

All are available at: http://www.in.gov/fssa/servicedisabl/waivers.html
And
http://www.in.gov/fssa/servicedisabl/provider/providerapproval.html

- Title 460 Division of Disability, Aging, and Rehabilitative Services Final Rule 460 IAC 6
- Person Centered Planning Guidelines
- Instructions for Completion of the Individualized Support Plan
- Incident Reporting Policy and Procedures
- Complaint Process
- A Guide for Individuals Working With the Bureau of Developmental Disabilities Services
- Who's Who Resources in the World of Autism and DD Waivers